

### Important information about opening a new account:

- Before completing this form, carefully read the **Plan Disclosure Booklet** and **Participation Agreement**.
- An eligible person can only have one ABLE account open at any time.
- Fill out all sections of this form to open a new ABLE for ALL Savings Plan account. If you want to reopen an old ABLE for ALL account then they should use the Account Reopen Form.
- You'll need to make an initial contribution of at least \$25 to start.
- If you connect a bank account to the ABLE account, the name of the Beneficiary or the Authorized Legal Representative must be associated with the bank account.
- Type or print clearly in black ink, and do not staple the pages or check.
- Refer to the Program Disclosure Booklet for the current yearly standard contribution limit.
- If you're making an ABLE to Work contribution, you may contribute an amount equal to the Beneficiary's gross income up to the current ABLE to Work contribution limit (see Program Disclosure Booklet for current limits) in addition to the yearly standard contribution limit.

### Need help?

Give us a call Monday – Friday  
from 9am – 8pm ET at  
**1-844-394-2253**

Individuals with speech or hearing disabilities may dial 711 to access Telecommunications Relay Service (TRS) from a telephone or TTY.

### Mail the form to:

ABLE for ALL Savings Plan  
PO Box 534430  
Pittsburgh, PA 15253- 4430

### Overnight Mail:

ABLE for ALL Savings Plan  
Attention: 534430  
500 Ross Street, 154-0520  
Pittsburgh, PA 15262

### Fax:

833-286-8167

### Want to enroll faster?

Go online to  
[www.ABLEforALL.com](http://www.ABLEforALL.com)

## 1 Is this a rollover from another ABLE plan?

- Yes (Please also fill out one of the applicable **Rollover Forms** in addition to this form.)
- No

## 2 Beneficiary information

\_\_\_\_\_  
Name (First and last)

\_\_\_ / \_\_\_ / \_\_\_\_\_  
Date of birth (mm/dd/yyyy)

How does the Beneficiary identify?  As she  As he  Chooses not to identify

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security or Taxpayer Identification Number

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Telephone number

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**Residential address**

No P.O. boxes are accepted for a residential address.

\_\_\_\_\_  
Street address 1

\_\_\_\_\_  
Street address 2

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

Does the beneficiary self-identify as a veteran?     Yes     No

**Are you an Authorized Legal Representative? If so, please complete Step 3.  
If not, disregard Step 3 and move on to Step 4.**

**3 Authorized Legal Representative information — If applicable**

\_\_\_\_\_  
Name (First and last)

**Relationship to the Beneficiary** (Please select one)  
I certify under the penalties of perjury that I am the Beneficiary's:

- |  |   |
|--|---|
| <input type="radio"/> <b>Power of Attorney</b><br>I have the Power of Attorney to open and manage an ABLÉ account for the Beneficiary.                               | <input type="radio"/> <b>Parent</b><br>I have the authority to open and manage an ABLÉ account for the Beneficiary.               |
| <input type="radio"/> <b>Legal Guardian</b><br>The Beneficiary does not have a Power of Attorney pertaining to this ABLÉ account, and I am their legal guardian.     | <input type="radio"/> <b>Sibling</b><br>I have the authority to open and manage an ABLÉ account for the Beneficiary.              |
| <input type="radio"/> <b>Conservator</b><br>The Beneficiary does not have a Power of Attorney pertaining to this ABLÉ account and I have been appointed conservator. | <input type="radio"/> <b>Grandparent</b><br>I have the authority to open and manage an ABLÉ account for the Beneficiary.          |
| <input type="radio"/> <b>Spouse</b><br>I have the authority to open and manage an ABLÉ account for the Beneficiary.  | <input type="radio"/> <b>Representative Payee</b><br>I have the authority to open and manage an ABLÉ account for the Beneficiary. |

\* The age of majority for most states is 18, with the following exceptions: Alabama (19), Mississippi (21), Nebraska (19).

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\_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

Date of birth (mm/dd/yyyy)

\_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

Social Security or Taxpayer Identification Number

\_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

Telephone number

### Residential address

No P.O. boxes are accepted for a residential address.

- Residential address is the same as the Beneficiary  
(Leave address information below blank)

\_\_\_\_\_  
Street address 1

\_\_\_\_\_  
Street address 2

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

**Want an easier way to enroll?**

Go online to [www.ABLEforALL.com](http://www.ABLEforALL.com) and use your email to set up an account.

**4 Communication preferences**

**Mailing address**

P.O. boxes are accepted for a mailing address.

- Use the Beneficiary’s residential address as the mailing address  
(Leave address information below blank)
- Use the Authorized Legal Representative’s residential address as the mailing address  
(Leave address information below blank)

Street address 1	Street address 2	
City	State	ZIP Code

Choose how you want to receive statements and tax forms (Please select one)

- Send digital tax forms, account information and quarterly statements by email  
(Please answer **Step 4A** below)
- Send digital quarterly statements and account information by email, but send tax forms by U.S. mail\*  
(Please answer **Step 4A** below)
- Send quarterly statements, account information and tax forms by U.S. mail\*  
(You’ll be charged \$10 per account, per year)
- A** What email address should we use?  
Answer if you’ve chosen to receive items by email

\_\_\_\_\_

Email

\* All documents sent by U.S. mail will be mailed to the account’s mailing address.

## 5 Diagnosis information

This information is needed to confirm the Beneficiary's eligibility for the ABLE program.

**Which option applies to the Beneficiary?** (Please select one)

I certify under the penalties of perjury that:

- The Beneficiary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act
- The Beneficiary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act
- The Beneficiary
  - a. has a medically determinable physical or mental impairment that results in marked and severe functional limitation\* and can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; OR is blind†

AND

- b. has a signed diagnosis (see our Physician's Form) from a licensed physician‡ as to the condition described in (a)

The Plan does not require you to submit documentation regarding the disability, but the IRS or Social Security Administration reserves the right to request this documentation and therefore you should retain proof in your personal records.

\* I understand that "marked and severe functional limitation" means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the "Listing"), but without regard to age. The Listing can be found at <https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1>. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary's prescribed treatment.

† I understand that, for purposes of eligibility for an ABLE account, "blind" means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a doctor of medicine (MD) or a doctor of osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at [https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502\(a\)](https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502(a)).

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**Diagnosis Code** (Please select one)

- Code 1: Developmental Disorder**  
Autistic Spectrum Disorder, Asperger's Disorder, Developmental Delays and Learning Disabilities
- Code 2: Intellectual Disability**  
Mild, moderate, or severe intellectual disability
- Code 3: Psychiatric Disorder**  
Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD), Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD) and Bipolar disorder
- Code 4: Nervous Disorder**  
Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease, Multiple sclerosis, Severe sensorineural hearing loss and Congenital cataracts
- Code 5: Congenital Anomalies**  
Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum, Spinal muscular atrophy, Fragile X syndrome and Edwards syndrome
- Code 6: Respiratory Disorder**  
Cystic Fibrosis
- Code 7: Other**  
Anything not listed under codes 1-6 and Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease and Hemophilia

Is this disability permanent\*?       Yes       No

**I certify under the penalties of perjury that:**

- The Beneficiary developed the disability or blindness before the age of 26
- The Beneficiary has no other ABLER account
- I will notify the Plan of any changes to the permanence\* of the Beneficiary's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence

\* Permanent/permanence is intended to mean a disability that "can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" as set forth in Section 529A of the Internal Revenue Code.

## 6 Work information

Providing employment information will help us understand how the account is being funded.

What is the Beneficiary or Authorized Legal Representative's work status? (Please select one)

- Employed    
  Self-Employed    
  Retired or Not Working



### A What's your occupation (Please select one)

Answer if **employed** or **self-employed**:

- |   |  |
|---|--|
| <input type="radio"/> Accounting/Auditing           | <input type="radio"/> Health Care Professional   |
| <input type="radio"/> Admin/Clerical                | <input type="radio"/> Hospitality/Food           |
| <input type="radio"/> Art/Antiques Dealer           | <input type="radio"/> Independent Investor       |
| <input type="radio"/> Banking Professional          | <input type="radio"/> Information Technology     |
| <input type="radio"/> Car/Boat/Airplane Dealer      | <input type="radio"/> Insurance                  |
| <input type="radio"/> Casino/Gaming                 | <input type="radio"/> Legal Services             |
| <input type="radio"/> Construction/Skilled Trade    | <input type="radio"/> Manufacturing/Production   |
| <input type="radio"/> Creative/Design/Architectural | <input type="radio"/> Nonprofit Executive        |
| <input type="radio"/> Defense/Military              | <input type="radio"/> Operations                 |
| <input type="radio"/> Editorial/Writing/Publishing  | <input type="radio"/> Other:                     |
| <input type="radio"/> Education                     | _____  |
| <input type="radio"/> Elected Official/Embassy      | (Please write in your occupation)                |
| <input type="radio"/> Engineering/Science/R&D       | <input type="radio"/> Public Service             |
| <input type="radio"/> Entertainment/Sports/Arts     | <input type="radio"/> Retail/Sales/Real Estate   |
| <input type="radio"/> Financial Services            | <input type="radio"/> Student                    |
|   | <input type="radio"/> Transportation/Warehousing |

### B Please choose all of your sources of income (Select all that apply)

Answer if **retired or not working**:

- Retirement Savings  
 Spousal Support  
 Social Security or Pension  
 Other:

\_\_\_\_\_  
 (Please write in all other sources)

**7 Successor Designated Beneficiary information - optional**

This information is needed to confirm the Successor Designated Beneficiary’s eligibility for this ABLÉ account. The Successor Designated Beneficiary is eligible to inherit the account if the Beneficiary dies or becomes incapacitated. By law, a Successor Designated Beneficiary for an account must be a sibling, step-sibling, or half-sibling of the Designated Beneficiary, and must also have a qualifying disability.

\_\_\_\_\_  
**Successor Designated Beneficiary name** (First and last)

\_\_\_ / \_\_\_ / \_\_\_\_\_  
**Date of birth** (mm/dd/yyyy)

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
**Social Security or Taxpayer Identification Number**

\_\_\_\_\_  
**Street address 1**

\_\_\_\_\_  
**Street address 2**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_ - \_\_\_\_\_  
**ZIP Code**

**Which option applies to the Successor Designated Beneficiary?** (Please select one)

**I certify under the penalties of perjury that:**

- The Successor Designated Beneficiary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act.
- The Successor Designated Beneficiary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act.
- The Successor Designated Beneficiary
  - a. has a medically determinable physical or mental impairment that results in marked and severe functional limitation\* and can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; OR is blind†
  - AND
  - b. has a signed diagnosis (see our Physician’s Form) from a licensed physician‡ as to the condition described in (a)

The Plan does not require you to submit documentation regarding the disability, but the IRS or Social Security Administration reserves the right to request this documentation and therefore you should retain proof in your personal records.

\* I understand that “marked and severe functional limitation” means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the “Listing”), but without regard to age. The Listing can be found at <https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1>. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary’s prescribed treatment.

† I understand that, for purposes of eligibility for an ABLÉ account, “blind” means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a doctor of medicine (MD) or a doctor of osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at [https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502\(a\)](https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502(a)).

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**Diagnosis Code** (Please select one)

- Code 1: Developmental Disorder  
Autistic Spectrum Disorder, Asperger’s Disorder, Developmental Delays and Learning Disabilities
- Code 2: Intellectual Disability  
Mild, moderate, or severe intellectual disability
- Code 3: Psychiatric Disorder  
Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD),  
Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD) and Bipolar disorder
- Code 4: Nervous Disorder  
Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington’s disease,  
Multiple sclerosis, Severe sensorineural hearing loss and Congenital cataracts
- Code 5: Congenital Anomalies  
Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum,  
Spinal muscular atrophy, Fragile X syndrome and Edwards syndrome
- Code 6: Respiratory Disorder  
Cystic Fibrosis
- Code 7: Other  
Anything not listed under codes 1-6 and Tetralogy of Fallot, Hypoplastic left heart syndrome,  
End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease and Hemophilia

**Is this disability permanent\*?**     Yes     No

**I certify under the penalties of perjury that:**

- The Successor Designated Beneficiary developed the disability or blindness before the age of 26
- I will notify the Program of any changes to the permanence\* of the Successor Designated Beneficiary’s disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence.
- The Successor Designated Beneficiary is a sibling, step-sibling, or half-sibling of the Designated Beneficiary.

Certification date    \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_  
(mm/dd/yyyy)

\* Permanent/permanence is intended to mean a disability that “can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months” as set forth in Section 529A of the Internal Revenue Code.

**8 Select an investment option**

There are four investment options to pick from. There are risks involved in investing. Your decision should be based on your goals and timeline for this ABLÉ account. The rest is determined by the market's performance.

**For an in-depth look at each of the investment options, please refer to the Plan Disclosure Booklet.**

How do you want to invest? (Please select at least one)

ABLE Conservative

A predesigned diversified option with a mix of stocks and bonds for a more conservative risk profile.

\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

ABLE Moderate

A predesigned diversified option with a mix of stocks and bonds for a more moderate risk profile.

\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

ABLE Aggressive

A predesigned diversified option with a mix of stocks and bonds for a more aggressive risk profile.

\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

Cash Option

This fund offers FDIC insurance protection for amounts contributed up to FDIC-permitted limits.

\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

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\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Total contribution amount

The investment information on this page has been provided by Sellwood Consulting, the investment advisor for the ABLÉ for ALL Savings Plan.

**9 Bank account information**

If you choose to make regular deposits and withdrawals with an ACH bank transfer, attach a voided check or copy of your bank statement showing the name, address, last 4 digits of the account number and complete the bank information below. (Please do not staple, use a paper clip for the check).

Bank account type     Checking     Savings

**Name on bank account**

The first and last name on the bank account needs to be the same as either the Beneficiary or the Authorized Legal Representative.

Bank name

Bank routing number

Bank account number

**Need help?**

You can find your bank information on the bottom of one of your checks here:

Routing Number	Account Number	1000

**10 Initial contribution information**

Which type of contribution are you making? (Please select one)

- Standard contribution  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution  
If the Beneficiary is earning wages, they may contribute an amount up to the ABLE to Work contribution limit (see Program Disclosure Booklet for current limits) in addition to the yearly standard contribution limit.\*

Promotional Code — If applicable

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions.

**11 Monthly contribution information — optional**

**Skip this step if you don't want to set up a monthly contribution at this time. You can set up monthly contributions in the future online.**

By setting up a monthly contribution, this will authorize us to initiate recurring ACH debits (direct withdrawals) from your bank account on the day you indicate of each month for the amount you set. You may cancel or change these recurring ACH debits (direct withdrawals) online or by using the **Manage Monthly Contributions Form**; however, we must receive your request at least 3 business days before you want it to become effective. We will continue to process transactions scheduled to occur before the end of the 3rd business day after you tell us to stop.

ABLE Conservative \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

ABLE Moderate \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

ABLE Aggressive \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

Cash Option \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Amount

\$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_  
Total contribution amount

\_\_\_\_  
**Withdrawal day (1–28)**  
If you don't pick a date, we'll automatically do it on the 1st of every month.

**Which type of contribution are you making?** (Please select one)

- Standard contribution  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution  
If the Beneficiary is earning wages, they may contribute an amount up to the ABLE to Work contribution limit (see Program Disclosure Booklet for current limits) in addition to the yearly standard contribution limit.\*

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions.

**12 Verify your identity**

We need any individuals linked to this account over the age of majority\* to provide identification.

How to provide identification

- If you are the Beneficiary, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary is under the age of majority\***, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary has reached the age of majority\***, please include Acceptable ID Documentation for yourself and the Beneficiary

**Acceptable ID Documentation****Option A**

Include a copy of a Department of Motor Vehicles State ID

**Option B**

Include a copy of both your Social Security card and your birth certificate

To help the government fight the funding of terrorism and money laundering, federal law requires us to obtain certain personal information, including your name, address, date of birth, and Social Security number or taxpayer identification number and other information that will allow us to verify your identity. If we are unable to verify your identity, we may have to close your account or take other steps we think are necessary.

\* The age of majority for most states is 18, with the following exceptions: Alabama (19), Mississippi (21), Nebraska (19).

## 13 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **Participation Agreement**. I understand and agree that those documents govern all aspects of this Account and are incorporated herein by reference.

I will retain a copy of the **Plan Disclosure Booklet** for my records. I understand that the ABLE for ALL Savings Plan may, from time to time, amend the **Plan Disclosure Booklet** and the **Participation Agreement**, and I understand and agree that I will be subject to the terms of those amendments.

I certify that all of the information provided by me on this **Enrollment Form** is, and all information provided by me in the future will be, true, complete and correct and I authorize the Plan to open this Account based upon this information.

Additionally, I certify under penalty of perjury:

- The beneficiary's disability or blindness is expected to result in death or has lasted, or can be expected to last for a continuous period of not less than 12 months and that I will notify the Plan of any change to the status of the beneficiary's disability or blindness (including any potential cure or remission of such disability or blindness) promptly upon such occurrence.
- If I've indicated that either my initial contribution or monthly contributions are ABLE to Work contributions I certify that the Beneficiary is earning wages and the amount being contributed is less than or equal to the Beneficiary's gross income up to the ABLE to Work contribution limit. I also certify if I'm making an ABLE to Work contribution that the Beneficiary (or the Beneficiary's employer) has not contributed to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year.
- I am seeking to establish an ABLE account as the eligible individual or have been selected by the eligible individual with legal capacity, or if the eligible individual is unable to establish their own ABLE account, I have the authority to establish the ABLE account as an agent under a power of attorney or, if none, as a conservator or legal guardian, spouse, parent, sibling, grandparent, or a representative payee appointed for the eligible individual by the Social Security Administration (SSA), in that order, and that there is no other person with a higher priority as listed above to establish the ABLE account.

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Signature of Beneficiary or Authorized Legal Representative

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Date (mm/dd/yyyy)

\* The age of majority for most states is 18, with the following exceptions: Alabama (19), Mississippi (21), Nebraska (19).