

Important information about using this form:

- Before completing this form, carefully read the Plan Disclosure Statement & Participation Agreement.
- Fill out this form to add, edit, or remove a Successor Designated Beneficiary from an ABLE for ALL Savings Plan 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 ABLE for ALL Savings Plan account must be a sibling, step-sibling, or half-sibling of the designated beneficiary, and must also have a qualifying disability.
- If something happens to the Beneficiary, the Successor Designated Beneficiary should contact customer service to assume the responsibility for the account. They will need to provide legal documentation (e.g. Death Certificate or other legal documents), as well as proof of their eligible disability.

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

1 ABLE for ALL account information

Name of the Beneficiary on the ABLE for ALL account (First and last)

____ _ – ____ _ – ____ _
Beneficiary's Social Security or Taxpayer Identification Number

____ _ – ____ _ – ____ _ – ____ _
ABLE for ALL account number

2 Manage Successor Designated Beneficiary information

(Please select one)

- ☐ Add a Successor Designated Beneficiary
- ☐ Change the Successor Designated Beneficiary
- ☐ Remove the Successor Designated Beneficiary (Skip to **Step 4**)

3 Successor Designated Beneficiary information

This information is needed to confirm the Successor Designated Beneficiary's eligibility for this ABLE for ALL account.

Successor Designated Beneficiary name (First and last)

____ / ____ / ____
Date of birth (mm/dd/yyyy)

____ - ____ - ____
Social Security or Taxpayer Identification Number

Residential address

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

Street address 1

Street address 2

City

State

____ - ____ - ____
ZIP Code

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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 limitations* 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 Successor Designated Beneficiary developed the disability or blindness before the age of 46
- ☐ 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.

4 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **Plan Disclosure Statement & Participation Agreement**. I understand and agree that those documents govern all aspects of this ABLE for ALL Savings Plan account and are incorporated herein by reference.

I will retain a copy of the **Plan Disclosure Statement & Participation Agreement** for my records. I understand that the ABLE for ALL Savings Plan may, from time to time, amend the **Plan Disclosure Statement & 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 form is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to change this ABLE for ALL account based upon this information.

Signature of Beneficiary or Authorized Legal Representative

Date (mm/dd/yyyy)