PAABLE

Enrollment Form

Important information about opening a new account:

- Before completing this form, carefully read the **PA ABLE Program Disclosure Statement and Participation Agreement.**
- An eligible person can only have one ABLE account at a time.
- Fill out all sections of this form to open a new PA ABLE account.
- If you connect a bank account to the PA ABLE account, the name of the Beneficiary or the Authorized Individual must be associated with the bank account.
- Type or print clearly in black ink, and do not staple the pages or check.
- Please see the **PA ABLE Program Disclosure Statement and Participation Agreement** for the current contribution limits.
- To help 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.

Need help?

Give us a call Monday – Friday from 9am – 8pm ET at **1-855-529-ABLE (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:
PA ABLE Savings Program
P.O. Box 534004
Pittsburgh, PA 15253-4004

Overnight Mail:
PA ABLE Savings Program
Attention: 534004
1350 Penn Avenue Suite 102
Pittsburgh, PA 15222

Fax:
855-851-7352

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. You can find forms at paable.gov).*

◯ **No**

2 Beneficiary (Account Owner) 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

Residential address

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

_____ _____

Street address 1 **Street address 2**

_____ _____ __ __ __ __ __ - __ __ __ __

City **State** **Zip Code**

Has the Beneficiary served in the military? ◯ Yes ◯ No

Are you an Authorized Individual opening this ABLE account on the Beneficiary's behalf? If so, please complete **Step 3**. If not, disregard **Step 3** and move on to **Step 4**.

3 Authorized Individual information — If applicable

_____

Authorized Individual Name (First and last)

Relationship to the Beneficiary
I certify under the penalties of perjury that (select either A or B):

◯ **A.** The Beneficiary is an adult with legal capacity to enter into a contract, and has selected me to serve as the Authorized Individual on their ABLE account

OR

◯ **B.** I am the Beneficiary's *(select one)*, and there are no other higher-priority individuals who are willing and able to manage the account:

- ☐ **1. Power of Attorney**
- ☐ **2. Conservator or Legal Guardian**
- ☐ **3. Spouse**
- ☐ **4. Parent**
- ☐ **5. Sibling**
- ☐ **6. Grandparent**
- ☐ **7. Representative Payee (appointed by the Social Security Administration)**

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

___ ___ ___ – ___ ___ – ___ ___ ___ ___
Social Security or **Taxpayer Identification Number**

___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___
Telephone Number

Authorized Individual's Residential Address

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

◯ Authorized Individual has the same address at the Beneficiary *(Leave address information below blank)*

Street address 1 _____

Street address 2 _____

City _____

State _____ **Zip Code** __ __ __ __ __ – __ __ __ __

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 Individual's residential address as the mailing address
(Leave address information below blank)

_____ _____
Street address 1 **Street address 2**

_____ _____ _____ – _____
City **State** **Zip Code**

_____
Email

Choose how you want to receive statements and tax forms for all the ABLE accounts you manage:
(Please select one)

◯ Receive tax forms, statements, and other documents electronically
By selecting this option, your Annual Account Maintenance Fee will be discounted by $20.

◯ Receive statements and other documents electronically, but receive tax forms by U.S. mail*

◯ Receive all documents by U.S. mail*
By selecting this option, you will be charged the full Annual Account Maintenance Fee, with no discount.

* 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 an ABLE account.

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 Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act

- ◯ The Beneficiary is entitled during the current year to Social Security Disability Insurance (SSDI) benefits based on blindness or disability under title II of the Social Security Act

- ◯ The Beneficiary
  a. has a medically determinable physical or mental impairment that results in marked and severe functional to 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 from a licensed physician‡ as to the condition described in (a)

  You do not need to submit documentation regarding the disability in order to open an account, but the Program and the IRS reserve the right to request this documentation. You should retain proof in your personal records.

* I understand that "marked and severe functional limitations" 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 by going to https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1 and clicking "Appendix 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.

Diagnosis Code *(Please select one)*

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

Is this disability permanent? ◯ Yes ◯ No

When did the disability begin?

- ◯ Before 26th birthday
- ◯ On or after 26th birthday, but before 46th birthday

I certify under the penalties of perjury that:

- ◯ The Beneficiary developed their disability or blindness before the age of 46
- ◯ The Beneficiary has no other ABLE account
- ◯ I will notify the Program of any changes to the Beneficiary's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence

6 Successor Designated Beneficiary information – optional

You may appoint a Successor Designated Beneficiary to become the owner of this ABLE account if the original Beneficiary dies. By law, a Successor Designated Beneficiary must be a sibling, step-sibling, or half-sibling of the original 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 Insurance (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 from a licensed physician‡
  as to the condition described in (a)

I understand that I am required to retain such signed diagnosis and to provide it to the Program or the IRS upon request, and I agree to do so.

* I understand that "marked and severe functional limitations" 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 by going to https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1 and clicking "Appendix 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.

Diagnosis Code for the Successor Designated Beneficiary (Please select one)

◯ Code 1: Developmental Disorder
Examples: Autistic Spectrum Disorder, Asperger's Disorder, Developmental delays, Learning Disabilities

◯ Code 2: Intellectual Disability
Examples: Mild, moderate, or severe intellectual disability

◯ Code 3: Psychiatric Disorder
Examples: Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD), Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD), Bipolar disorder

◯ Code 4: Nervous Disorder
Examples: Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease, Multiple sclerosis, Severe sensorineural hearing loss, Congenital cataracts

◯ Code 5: Congenital Anomalies
Examples: Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum, Spinal muscular atrophy, Fragile X syndrome, Edwards syndrome

◯ Code 6: Respiratory Disorder
Example: Cystic Fibrosis

◯ Code 7: Other
Anything not listed under codes 1-6; *examples:* Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease, Hemophilia

Is this disability permanent*? ◯ Yes ◯ No

I certify under the penalties of perjury that:

◯ The Successor Designated Beneficiary developed their disability or blindness before the age of 46

◯ I will notify the program of any changes to 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 original Beneficiary.

__ __ / __ __ / __ __ __ __
Certification date (mm/dd/yyyy)

7 Contribution information

You must contribute at least $1 to each portfolio you want to add money to. You can connect a bank account (**Step 9**) or include a check made out to PA ABLE.

You can select as many portfolios as you want. The allocations you select here will apply to your initial and future contributions. You change your future contribution allocations at any time. You can also exchange already invested funds up to twice per calendar year.

Please read the PA ABLE Program Disclosure Statement and Participation Agreement for important information about the investment options before making a decision.

Risk-Based Portfolios

- ☐ Capital Preservation Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Conservative Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Moderately Conservative Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Moderate Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Growth Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Moderately Aggressive Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ☐ Aggressive Portfolio — $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**

Target Year Portfolios

- ◯ Target year 2030 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2035 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2040 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2045 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2050 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2055 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2060 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2065 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
- ◯ Target year 2070 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**

$ ___ ___ , ___ ___ ___ . ___ ___ **Total amount**

How are you making this contribution?

◯ Check (Please include a check made out to PA ABLE with a paper clip, do not staple)

◯ Electronic bank transfer (Please fill out **Step 9**)

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

◯ **Standard contribution**
See the PA ABLE Program Disclosure Statement and Participation Agreement for the current yearly standard contribution limit.

◯ **ABLE to Work contribution**
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see The PA ABLE Program Disclosure Statement and Participation Agreement for current limits), in addition to the yearly standard contribution limit.*

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

8 Monthly contribution information — If applicable

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 electronic 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 debits online or by calling our customer service team; 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.

Below, tell us how much you want to contribute to each portfolio each month. There is a $1 minimum contribution to each portfolio you select.

Risk-Based Portfolios

☐ Capital Preservation Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Conservative Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Moderately Conservative Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Moderate Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Growth Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Moderately Aggressive Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
☐ Aggressive Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**

Target Year Portfolios

◯ Target year 2030 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**	◯ Target year 2055 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
◯ Target year 2035 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**	◯ Target year 2060 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
◯ Target year 2040 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**	◯ Target year 2065 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
◯ Target year 2045 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**	◯ Target year 2070 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
◯ Target year 2050 $ ___ ___ , ___ ___ ___ . ___ ___ **Amount**	_____ $ ___ ___ , ___ ___ ___ . ___ ___ **Total amount**

Contribution Day (1-28)*
If you don't pick a date, we'll automatically deduct your contribution on the 1st of every month

___ ___

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* A note on when contributions will be deducted from your bank account: If the Contribution Day you've selected falls on a regular business day, your contribution will be deducted from your bank account two business days prior to the Contribution Day. If the Contribution Day you've selected falls on a weekend or a holiday, the contribution will be deducted from your bank account on the next Business Day.

Which type of contribution will your monthly deposit be? *(Please select one)*

◯ **Standard contribution**
See the PA ABLE Program Disclosure Statement and Participation Agreement for the current yearly standard contribution limit.

◯ **ABLE to Work contribution**
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see The PA ABLE Program Disclosure Statement and Participation Agreement for current limits), in addition to the yearly standard contribution limit.*

9 Bank account information

Attach a voided check or copy of your bank statement showing the name, address, the account number and complete the bank information below. *(Please do not staple, use a paper clip for the check.)*

What type of documentation are you including to verify this bank account?

◯ Voided Check

◯ Bank statement

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 Individual.

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:

A 000000000 A 00000000000 c 1000
Routing Number — Account Number

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

10 Verify your identity

We need any individuals linked to this account over the age of 18 to provide identification.

How to provide identification

- ◯ If you are the Beneficiary, please include Acceptable ID Documentation for yourself
- ◯ If you are the Authorized Individual **and the Beneficiary is under 18**, please include Acceptable ID Documentation for yourself
- ◯ If you are the Authorized Individual **and the Beneficiary is over 18**, 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 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.

11 Sign the form

By signing below, I acknowledge that I have received, read, understand, and agree to the terms and conditions set forth below and in the **PA ABLE Program Disclosure Statement & 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 **PA ABLE Program Disclosure Statement & Participation Agreement** for my records. I understand that the Program may, from time to time, amend the **PA ABLE Program 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 **Enrollment Form** is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to open this account based upon this information.

Additionally, I certify under penalty of perjury:

- The Beneficiary's disability or blindness began before age 46 and 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 program 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.
- I certify that the Beneficiary does not have any other ABLE account, except in connection with a permitted rollover or program-to-program transfer as described in the PA ABLE Program Disclosure Statement & Participation Agreement, and I understand that a Beneficiary may only have one ABLE account at a time.
- If I am opening this account on the Beneficiary's behalf, I have authority to act as the Beneficiary's Authorized Individual on this ABLE account. I understand that only certain persons can serve as an Authorized Individual, and that there is an order of priority for who can serve. Specifically, I understand that the order of priority is:
- (1) a person selected by the Beneficiary (when the Beneficiary also has legal capacity to enter into a contract), (2) the Beneficiary's agent under power of attorney, (3) conservator or legal guardian, (4) spouse, (5), parent, (6) sibling, (7) grandparent, or (8) a representative payee appointed for the Beneficiary by the Social Security Administration. I certify that I am qualified under this prioritized list to serve as the Beneficiary's Authorized Individual, and that there is no other person higher than me on the prioritized list who is both willing and able to serve as the Beneficiary's Authorized Individual on this account. I further certify that: (1) this account is in the best interest of the Beneficiary; (2) that I neither have, nor will I acquire, any beneficial interest in the Beneficiary's ABLE account during the Beneficiary's lifetime; and (3) that I will administer the ABLE account for the benefit of the Beneficiary.
- 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 this calendar year and is no more than the current limits (see The PA ABLE Program Disclosure Statement and Participation Agreement for current limits). 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.

_____ __ __ / __ __ / __ __ __ __

Signature of Beneficiary or Authorized Individual **Date** (mm/dd/yyyy)