

**Important information about opening a new account:**

- Before completing this form, carefully read the **Plan Disclosure Statement & 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 STABLE account.
- You'll need to make an initial contribution of at least \$25 to start.
- If you connect a bank account to the STABLE 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.
- Please see the Plan Disclosure Statement & Participation Agreement for the current yearly 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 limits (see Plan Disclosure Statement for current limits), in addition to the annual standard contribution limit.
- 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.

**Need help?**

Give us a call Monday – Friday  
from 9am – 8pm ET at  
**1-800-439-1653**

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

**Mail the form to:**

STABLE Account Plan  
PO Box 534425  
Pittsburgh, PA 15253- 4425

**Overnight Mail:**

STABLE Account Plan  
Attention: 534425  
500 Ross Street, 154-0520  
Pittsburgh, PA 15262

**Fax:**

844-745-9612

**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 [STABLEaccount.com](https://stableaccount.com)
- 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**

**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**

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

\_\_\_ / \_\_\_ / \_\_\_\_\_  
**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.

- Authorized Legal Representative has the same address as 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 Legal Representative'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 accounts you manage**  
(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 \$20 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 STABLE 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 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 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 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

**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 the disability or blindness before the age of 46
- The Beneficiary has no other ABLER account
- I will notify the Program 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 Successor Designated Beneficiary information - optional**

This information is needed to confirm the Successor Designated Beneficiary’s eligibility for this STABLE 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 a STABLE 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)

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 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 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.

**7 Contribution information**

There's a \$25 minimum contribution to open an account and you must contribute at least \$1 to each portfolio or fund you want to add money to. You can connect a bank account (**Step 9**) or include a check made out to STABLE account.

You can select as many portfolios you want to invest your contributions. You can view your portfolio allocations at any time or change your investment strategy up to twice per calendar year.

Please read the STABLE account **Plan Disclosure Statement & Participation Agreement** for important information about the cash and investment options before making a decision.

**With an investment portfolio**

- This portion of your money is usually set aside for longer term investment.
- There is a risk of losing money, even your contributions, but you may also gain money over time.
- Each option has varying degree of risk, going up and down in value depending on the market.

**With the STABLE Savings Option**

This portion of your money is usually set aside for short term saving or on-going spending needs.

- There's low risk, but minimal or no interest.
- The account is FDIC insured up to the allowable amount.

**Investment options**

Growth Portfolio	\$ ____ , ____ . ____ Amount
Moderate Growth Portfolio	\$ ____ , ____ . ____ Amount
Conservative Growth Portfolio	\$ ____ , ____ . ____ Amount
Income Portfolio	\$ ____ , ____ . ____ Amount
STABLE Savings Option	\$ ____ , ____ . ____ Amount

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

The investment information on this page has been provided by Marquette Associates, the investment advisor for the STABLE account Program.

**How are you making this contribution?**

- Check (Please include a check made out to STABLE account with a paper clip, do not staple)
- ACH deposit (Please fill out **Step 9**)

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

- Standard contribution**  
See the STABLE account Plan Disclosure & 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 Plan Disclosure Statement 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.

**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 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 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.

**Investment options**

Tell us how much you want to contribute to your account each month. There is a \$1 minimum contribution to each portfolio you select.

Growth Portfolio	\$ ___ , ___ . ___ Amount
Moderate Growth Portfolio	\$ ___ , ___ . ___ Amount
Conservative Growth Portfolio	\$ ___ , ___ . ___ Amount
Income Portfolio	\$ ___ , ___ . ___ Amount
STABLE Savings Option	\$ ___ , ___ . ___ Amount
	\$ ___ , ___ . ___ Total contribution amount

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

- Standard contribution**  
See the STABLE account Plan Disclosure & 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 (see Plan Disclosure Statement for current limits) in addition to the yearly standard contribution limit.

**Contribution Day\***

If you don't pick a date, we'll automatically deduct your contribution on the 1st of every month.

\_\_\_  
(1-28)

\* 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.

**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:

 0000000000 0000000000 1000  
Routing      Account  
Number      Number

\* 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.

**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 or Successor Owner, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary or Successor Owner is under 18**, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary or Successor Owner is over 18**, please include Acceptable ID Documentation for yourself and the Beneficiary or Successor Owner

**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

**11 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 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 STABLE account Program 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 **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 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.
- If I’ve indicated that either my initial contribution or monthly contributions are ABLÉ 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 Plan Disclosure Statement for current limits). I also certify if I’m making an ABLÉ 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 ABLÉ 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 ABLÉ account, I have the authority to establish the ABLÉ account as an agent under a power of attorney or, if none, by a conservator or legal guardian, spouse, parent, sibling, grandparent of the eligible individual, 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 ABLÉ account.

\_\_\_\_\_  
Signature of Beneficiary or Authorized Legal Representative

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