Important information about opening a new account:

- Before completing this form, carefully read the **Program Disclosure Statement**
- An eligible person can only have one ABLE account open at any time.
- Fill out all sections of this form to open a new CalABLE account.
- You'll need to make an initial contribution of at least $25 to start.
- If you connect a bank account to the CalABLE 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 Program Disclosure Statement 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 Program 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 6am – 5pm PT at
1-833-Cal-ABLE
(833-225-2253)

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

Mail the form to:
CalABLE
P.O. Box 534403
Pittsburgh, PA 15253- 4403

Overnight Mail:
CalABLE
Attention: 534403
500 Ross Street, 154-0520
Pittsburgh, PA 15262

Fax:
844-761-0239

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 CalABLE.ca.gov)

◯ **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 PO boxes are accepted for a residential address.

_____ _____

Street address 1 **Street address 2**

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

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

Does the Beneficiary 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:

- ◯ **Power of Attorney**
  I have the Power of Attorney to open and manage a CalABLE account for the Beneficiary.
- ◯ **Legal Guardian**
  The Beneficiary does not have a Power of Attorney pertaining to this CalABLE account, and I am their legal guardian.
- ◯ **Conservator**
  The Beneficiary does not have a Power of Attorney pertaining to this CalABLE account, and I have been appointed conservator.
- ◯ **Spouse**
  I have the authority to open and manage a CalABLE account for the Beneficiary.
- ◯ **Parent**
  I have the authority to open and manage a CalABLE account for the Beneficiary.
- ◯ **Sibling**
  I have the authority to open and manage a CalABLE account for the Beneficiary.
- ◯ **Grandparent**
  I have the authority to open and manage a CalABLE account for the Beneficiary.
- ◯ **Representative Payee**
  I have the authority to open and manage a CalABLE account for the Beneficiary.

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

__ __ __ - __ __ - __ __ __ __
Social Security or **Taxpayer Identification Number**

__ __ __ - __ __ __ - __ __ __ __
Telephone Number

Authorized Legal Representative's Residential Address

No PO boxes are accepted for a residential address.

◯ Authorized Legal Representative 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

PO 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 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 $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 URS 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).

continued from page 6

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 ABLE 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 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**:

- ◯ Accounting/Auditing
- ◯ Admin/Clerical
- ◯ Art/Antiques Dealer
- ◯ Banking Professional
- ◯ Cannabis related business
- ◯ Car/Boat/Airplane Dealer
- ◯ Casino/Gaming
- ◯ Construction/Skilled Trade
- ◯ Creative/Design/ Architectural
- ◯ Defense/Military
- ◯ Editorial/Writing/Publishing
- ◯ Education
- ◯ Elected Official/Embassy
- ◯ Engineering/Science/R&D
- ◯ Entertainment/Sports/Arts
- ◯ Financial Services
- ◯ Health Care Professional
- ◯ Hospitality/Food
- ◯ Independent Investor
- ◯ Information Technology
- ◯ Insurance
- ◯ Legal Services
- ◯ Manufacturing/Production
- ◯ Nonprofit Executive
- ◯ Operations
- ◯ Other:

_____
(Please write in your occupation)

- ◯ Public Service
- ◯ Retail/Sales/Real Estate
- ◯ Student
- ◯ 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 Government Services
- ◯ 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 CalABLE 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 Beneficary 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 Beneficary 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 Beneficary
  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 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).

continued from page 9

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 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 CalABLE.

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

Please read the CalABLE Program Disclosure Statement for important information about the cash and investment options before making a decision.

Investment Options:

☐ FDIC Insured Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Income Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Conservative Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Income and Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Balanced Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Conservative Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Moderate Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**

$ __ __ __ , __ __ __ . __ __
Total contribution amount

The investment information on this page has been provided by BNY Mellon Advisors, Inc., formerly known as Lockwood Advisors Inc., the investment sub-advisor for CalABLE.

Continued from page 11

How are you making this contribution?

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

◯ ACH deposit (Please fill out **Step 10**)

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

◯ Standard contribution
See the CalABLE Program Disclosure Statement 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 Program 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.

9 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 (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.

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.

☐ FDIC Savings Fund	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Income Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Conservative Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Income and Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Balanced Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Conservative Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Moderate Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
☐ Growth Portfolio	**$** __ __ __ , __ __ __ . __ __ **Amount**
__ __ **Contribution Day** (1-28)* If you don't pick a date, we'll automatically deduct you contribution on the 1st of every month	**$** __ __ __ , __ __ __ . __ __ **Total contribution amount**

Continued from page 13

* 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 are you making? (Please select one)

◯ Standard contribution
See the CalABLE Plan Disclosure Statement 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 Program Disclosure Statement for current limits), in addition to the yearly standard contribution limit.*

10 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 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:

A000000000 A 00000000000000 c 1000

Routing Number | Account 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.

11 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 Legal Representative **and the Beneficiary is under 18**, please include Acceptable ID Documentation for yourself
- ◯ If you are the Authorized Legal Representative **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

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.

12 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **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 **Program Disclosure Statement & Participation Agreement** for my records. I understand that the CalABLE program may, from time to time, amend the **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 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'm either a parent, a legal guardian, or have Power or Attorney, which makes me an Authorized Legal Representative. I am authorized to act on the Beneficiary's behalf in opening the Account and that this Account is in the best interest 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 Program Disclosure Booklet 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 Legal Representative **Date** (mm/dd/yyyy)