OREGON ABLE SAVINGS PLAN

Enrollment Form

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 **Oregon ABLE Savings Plan** account.
- You'll need to make an initial contribution of at least $25 to start off the account.
- 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.

Need help?
Give us a call Monday – Friday from 9am – 5pm PT at **1-844-999-ABLE** or from 6am – 5pm PT at **1-844-888-ABLE (TTY)**

Mail the form to:
Oregon ABLE Savings Plan
P.O. Box 9891
Providence, RI 02940-8091

Want to enroll faster?
Go online to www.OregonAbleSavings.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. You can find forms at www.OregonAbleSavings.com/forms.)

◯ No

2 Beneficiary information

_____

Name (First and last)

__ __ – __ __ – __ __ __ __

Birthday (mm/dd/yyyy)

How does the Beneficiary identify? ◯ As a she ◯ As a he ◯ Choose not to identify

__ __ __ – __ __ – __ __ __ __

Social Security or Taxpayer Identification Number

__ __ __ – __ __ __ – __ __ __ __

Telephone number

continued on page 2

continued from page 1

Street Address 1 | Street Address 2

City | County | State | ZIP Code

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

3 Authorized Legal Represention information — If applicable

Name (First and last)

Relationship to the Beneficiary
I certify under the penalties of perjury that I am the Beneficiary's:

- ◯ I have Power of Attorney
  I have the Power of Attorney to open and manage an ABLE account for the Beneficiary.
- ◯ I'm a Parent / Legal Guardian
  The Beneficiary does not have a Power of Attorney pertaining to this ABLE account, and I am their parent or legal guardian.

__ __ – __ __ – __ __ __ __
Birthday (mm/dd/yyyy)

__ __ __ – __ __ – __ __ __ __
Social Security or Taxpayer Identification Number

__ __ __ – __ __ __ – __ __ __ __
Telephone number

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

Street Address 1 | Street Address 2

City | County | State | ZIP Code

4 Communication preferences

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

- ◯ Send digital tax forms and quarterly statements by email
  (Please answer **Step 4A** below)
- ◯ Send digital quarterly statements by email, but mail* tax forms via snail mail
  (Please answer **Step 4A** below)
- ◯ Mail* quarterly statements and tax forms
  (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

Want an easier way to enroll?
Go online to www.OregonAbleSavings.com and use your email to set up an account.

* All tax forms and statements will be mailed to the Beneficiary's address.

5 Diagnosis information

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

Which option applies to the Benficiary? (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 Supplimental 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)

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

continued on page 4

* 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 www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm. 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.

continued from page 3

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 was diagnosed with the above disability or blindness before the age of 26
- ◯ The Beneficiary has no other ABLE account
- ◯ I will notify the Plan of any changes to the permanence* of the Beneficiary's disability or blindess (including any potential cure for such disability or blindness) promptly upon such an occurence

* 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** and **self employed:**

- ◯ Accounting/Auditing
- ◯ Admin/Clerical
- ◯ Art/Antiques Dealer
- ◯ Banking Professional
- ◯ 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 Choose where to put your money

You can put your money in an investment and/or cash option. Future contributions and withdrawals will be allocated to help bring your account to your target allocation of cash and investment balances.

Please read the Oregon ABLE Savings **Plan Disclosure Booklet** for important information about the cash and investment options before making a decision.

If you decide to invest, you have to allocate at least 10% of your money to the investment.

With an investment allocation

- This portion of your money is usually set aside for longer term investment.
- There's the 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.
- It can take up to 5–7 business days to receive money once you start a withdrawal.
- Learn about the three portfolio options, ABLE Conservative, ABLE Moderate, and ABLE Aggressive in the **Plan Disclosure Booklet** before you pick one in the next step.

With a cash allocation

- 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.
- It can take up to 3–5 business days to receive money once you start a withdrawal.

How would you like to allocate your money?
(Must equal to 100%)

_____ %

Invested (Must be either 0% or at least 10%)

_____ %

Cash Option

If you invested, fill out **Step 8.** If you chose not to invest and put all of your money in the cash allocation, you can skip to **Step 9.**

Still undecided about the cash and/or investment allocation?
Check out the question: "How transfers work?" in the FAQs section on www.OregonAbleSavings.com for more information.

The investment information on this page has been provided by Sellwood Consulting, the investment advisor for the Oregon ABLE Savings Plan

8 Select an investment option

Skip this step if you chose to put all of your money in the cash allocation.

There are three investment options to pick from. There are risks involved in investing, your decision should be based on your goals and timeline for this ABLE account. The rest is up to 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 one)

◯ ABLE Conservative
This option seeks to provide current income and some growth by investing in a portfolio of mutual funds that consists of 20% global public stocks and 80% bonds. Overall, there's a small amount of risk and limited appreciation potential, designed for a shorter investment period.

◯ ABLE Moderate
This option seeks to provide a combination of growth and current income by investing in a portfolio of mutual funds that consists of 50% global public stocks and 50% bonds. Overall, there's a medium level of risk for a pursuit of investment return, designed for a medium or uncertain time horizon.

◯ ABLE Aggressive
This option provides the potential to grow by investing in a portfolio of mutual funds that consists of 84% global public stocks and 16% bonds. Overall, there's a high level of risk and potential for return (or loss), designed for a longer investment period (10 years or more).

The investment information on this page has been provided by Sellwood Consulting, the investment advisor for the Oregon ABLE Savings Plan

9 Bank 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

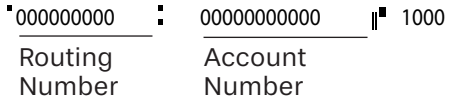
Name on Bank Account
The last name on the bank account needs to be the same as either the Beneficiary or the Authorized Legal Representative.

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:



10 Contribution information

$

Initial Contribution Amount (Minimum is $25.00)
The amount will be taken out of the bank account you provided in Step 8. Please disregard if you are including a check made out to Oregon ABLE Savings Plan.

Who's making the initial contribution?

◯ Beneficiary

◯ Authorized Legal Representative
(We don't allow representative payees)

Would you like to make 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) at any time by calling 1-844-999-ABLE or 1-844-888-ABLE for TTY; 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.

◯ Yes
If so, how much and when:

$

Amount

Day (1-28)
If you don't pick a date, we'll automatically do it on the 1st of every month.

◯ No

11 Identification

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 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 identify. 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 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 Oregon ABLE 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.
- I'm either a parent, a legal guardian, or have Power of 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.

Signature of Beneficiary or Authorized Legal Representative _____ **Date** (mm/dd/yyyy) _____