

## Important information about using this form:

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

## Need help?

Give us a call Monday – Friday from 9am – 5pm PT at

**1-844-999-2253**

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

## Mail the form to:

Oregon ABLE Savings Plan  
P.O. Box 534430  
Pittsburgh, PA 15253- 4430

## Overnight Mail:

Oregon ABLE Savings Plan  
Attention: 534430  
500 Ross Street, 154-0520  
Pittsburgh, PA 15262

## Fax:

833-286-8167

## 1 Oregon ABLE account information

\_\_\_\_\_  
Name of the Beneficiary on the Oregon ABLE account (First and last)

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Beneficiary's Social Security or Taxpayer Identification Number

O R - \_\_\_\_\_  
Oregon ABLE account number

## 2 Manage Successor Designated Beneficiary information

(Please select one)

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

### 3 Successor Designated Beneficiary information

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

\_\_\_\_\_  
**Successor Designated Beneficiary name** (First and last)

\_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_  
**Date of birth** (mm/dd/yyyy)

\_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  
**Social Security or Taxpayer Identification Number**

#### **Residential address**

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

\_\_\_\_\_  
**Street address 1**

\_\_\_\_\_  
**Street address 2**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**      **ZIP Code**      \_\_\_\_\_

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**Which option applies to the Successor Designated Beneficiary?** (Please select one)

I certify under the penalties of perjury that:

- The Successor Designated Beneficiary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act.
- The Successor Designated Beneficiary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act.
- The Successor Designated Beneficiary
  - a. has a medically determinable physical or mental impairment that results in marked and severe functional 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.

\* I understand that "marked and severe functional limitation" means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the "Listing"), but without regard to age. The Listing can be found at <https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1>. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary's prescribed treatment.

† I understand that, for purposes of eligibility for an ABLE account, "blind" means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a doctor of medicine (MD) or a doctor of osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at [https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502\(a\)](https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502(a)).

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**Diagnosis Code** (Please select one)

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

**Is this disability permanent\*?**     Yes     No

**I certify under the penalties of perjury that:**

- The Successor Designated Beneficiary developed the disability or blindness before the age of 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.

## 4 Sign the form

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

I will retain a copy of the **Plan Disclosure Statement & Participation Agreement** for my records. I understand that the Oregon ABLE Savings Plan may, from time to time, amend the **Plan Disclosure Statement & Participation Agreement**, and I understand and agree that I will be subject to the terms of those amendments.

I certify that all of the information provided by me on this form is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to change this Oregon ABLE account based upon this information.

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**Signature of Beneficiary or Authorized Legal Representative**

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**Date** (mm/dd/yyyy)