

Important information about this form:

- Use this form to reopen an account that was previously closed.
- A separate form is needed for each account.
- The Beneficiary or the Authorized Legal Representative must sign this form.
- Keep in mind that all communications are sent to the mailing address listed on the account.
- You can't make withdrawals by check for 30 days following the change of your address unless either this form or the **Withdrawal Form** includes a notarization acknowledgement (**Step 6**).

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 9891
Providence, RI 02940-8091

Overnight Mail:

Oregon ABLE Savings Plan
4400 Computer Drive
Westborough, MA 01581

1 ABLE account information

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

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

____ _ - ____ _ - ____ _ - ____ _
Oregon ABLE Savings Plan account number

2 Which addresses do you want to change (as applicable)?

(Select all that apply if the addresses are the same)

- The Beneficiary's residential address
- Mailing address (address where any account-related information will be sent)

3 New contact information (as applicable)

If the Beneficiary moves out of the state of Oregon, they can keep their ABLE account and continue to use it.

If you're updating the Beneficiary's address, it cannot be a P.O. box.

Street address 1

Street address 2

City

State

ZIP Code

Telephone number

Email address**4 Diagnosis information**

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 Plan 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

5 Sign the form

By signing this form, you're confirming your intent to reopen the above account.

Signature of Beneficiary or Authorized Legal Representative

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.

6 A notarization acknowledgement is required for a change of address

If you want to avoid a 30-day hold period associated with the addition or change in address information, please have your signature notarized below.

Keep in mind that:

- You're providing the following information as underwritten certification that your signature is genuine.
- You cannot guarantee your own signature. You may be required to provide proof of your authority to act on behalf of the ABLE account.

Only sign if you are in the presence of a notary public or other officer providing notarization.

The undersigned has read the foregoing in its entirety before signing. IN WITNESS WHEREOF, I have hereunto

set my hand this _____ day of _____, 20____.

Day (#) Month Year

Signature of Beneficiary or Authorized Legal Representative

State of Oregon, County of _____

This instrument was acknowledged before me

physical presence online notarization

on _____
Date (mm/dd/yyyy)

by _____
Name of person (First and last)

My term expires: _____
Date (mm/dd/yyyy)

Notary Public (Seal)

Signature of Notary Public