



- Use this form when requesting a change of account owner or successor owner on your ABLEAmerica account.
- All existing account options will be removed if you are changing the account owner and transferring the entire balance. To retain your account options, call us at **(800) 421-4225**.
- If the account owner is changing his or her name, obtain and complete a *Name Change Request*.
- If the current account owner/authorized representative is deceased, call us. **The new account owner/authorized representative must sign Section 6.**

## 1 Current account owner

|                                     |      |               |
|-------------------------------------|------|---------------|
| First name of current account owner | MI   | Last          |
| Address                             | City | State ZIP     |
| Email address*                      |      | Daytime phone |

Name of current authorized representative (if applicable) Account number

\*Your privacy is important to us. For information on our privacy policies, visit [www.capitalgroup.com](http://www.capitalgroup.com).

## 2 Account owner change — if applicable

Complete A, B and C. A signature guarantee is required.

**Important: The transfer of account ownership to another individual may have tax consequences. Consult your tax professional for additional information.**

**Account owner** — the person who establishes and controls the account (unless an authorized representative establishes and controls the account), and who is entitled to receive its benefits for disability expenses. The account owner is also the beneficiary.

### A. New account owner information

|   |  |                        |
|---|--|------------------------|
| <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SSN | <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of birth (mm/dd/yyyy) | Country of citizenship |
|---|--|------------------------|

First name of account owner MI Last

Residence address (physical address required — **no P.O. boxes**) City State ZIP

Mailing address (if different from residence address) City State ZIP

Email address\* Daytime phone

Relationship to former account owner

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## 2 Account owner change — if applicable

(continued)

By completing this section and signing in Section 6, you certify under penalties of perjury that: **1**) The codes checked in 1 and 2 below are correct; **2**) the account owner developed the disability or blindness before the age of 46; **3**) the account owner has no other ABLE account, except in the case of a transfer or rollover from another ABLE account; and **4**) you will notify ABLEAmerica if changes in the account owner's condition would result in the account owner no longer qualifying as an eligible individual.

**B. Account owner eligibility.** This information will be used for tax reporting purposes. You must complete 1, 2 and 3.

**1. Select the basis for ABLE account eligibility. (Select one.)**

- Code A — account owner is entitled to Social Security Disability Insurance (SSDI) under title II of the Social Security Act.
- Code B — account owner is entitled to supplemental security income (SSI) under title XVI of the Social Security Act.
- Code C — account owner has a signed licensed physician's diagnosis that he or she is either (a) blind (within the meaning of the Social Security Act); (b) has a medically determinable physical or mental impairment which results in marked and severe functional limitations and which can be expected to result in death or has lasted (or can be expected to last) for a continuous period of no less than 12 months; and/or (c) has a condition listed in the "List of Compassionate Allowances Conditions" maintained by the Social Security Administration.

The diagnosis does not need to be included with this document, but you must retain and provide a copy to ABLEAmerica or the IRS upon request.

**2. Indicate the account's owner's disability type. (Select one.)**

|  |   |
|--|---|
| <input type="checkbox"/> Code 1 — Developmental disorder                                     | <input type="checkbox"/> Code 2 — Intellectual disability |
| <input type="checkbox"/> Code 3 — Psychiatric disorder                                       | <input type="checkbox"/> Code 4 — Nervous disorder        |
| <input type="checkbox"/> Code 5 — Congenital anomaly   | <input type="checkbox"/> Code 6 — Respiratory disorder    |
| <input type="checkbox"/> Code 7 — Other (any other disability not listed under Codes 1 to 6) |   |

**3. Is the disability permanent?**  Yes  No

If no, you will be asked to certify annually that the account owner continues to satisfy eligibility requirements.

**C. Transfer instructions — required**

Transfer the entire amount from the ABLEAmerica account listed in Section 1 to the new account.

**OR**

Transfer the following amount(s) from the ABLEAmerica account listed in Section 1 to the new account:

| Fund name or number | Amount   | Percentage |
|---------------------|----------|------------|
| _____               | \$ _____ | OR _____ % |
| _____               | \$ _____ | OR _____ % |
| _____               | \$ _____ | OR _____ % |

**Note:** Funds will be transferred in kind to the new or existing account in the same share class(es), fund(s) and percentage(s) as they were withdrawn, unless otherwise instructed below.

**New investment instructions:**

| Fund name or number | Amount   | Percentage |
|---------------------|----------|------------|
| _____               | \$ _____ | OR _____ % |
| _____               | \$ _____ | OR _____ % |
| _____               | \$ _____ | OR _____ % |

### **3 Successor owner change — if applicable**

*The successor owner named in this section will replace any existing successor owner listed on the account.*

#### **New successor owner designation**

The successor owner becomes the owner of the account upon the death of the original account owner. The transfer of account ownership to another individual may have tax consequences. Consult your tax professional for additional information.

First name of successor owner

MI

Last

-   -

Date of birth of successor owner (mm/dd/yyyy)

### **4 Additional options — if applicable**

*If a new account owner has been named in Section 2, this section should be presented to them for review.*

**A. Online/telephone exchange and withdrawal privileges will automatically be enabled on your account unless you decline below. To decline these privileges, read the individual statements and check the applicable box(es).**

**Note:** If either option is declined, no one associated with this account, including your financial professional, will be able to request exchanges and/or withdrawals via the website or by telephone. Requests would need to be submitted in writing.

**Exchanges:** I DO NOT want the option of using the online/telephone exchange privilege.

**Withdrawals:** I DO NOT want the option of using the online/telephone withdrawal privilege.

**Important note:**

IRS rules limit changes in ABLE investment strategy to two per year. You may establish an automatic exchange plan or rebalance option at the time of account setup. Adding or changing an automatic exchange plan or requesting the rebalance option on an existing account will be considered a change in investment strategy. The request may be denied if a change in investment strategy exceeds two per year. Refer to the *ABLEAmerica Program Description* for additional information or speak with a financial professional. You may only exchange from one fund to another or rebalance funds within the same share class.

**B. Rights of Accumulation (cumulative discount)**

Account owner, spouse and children under 21 or disabled adult children with ABLE accounts can aggregate accounts to reduce sales charges. Any share classes within these accounts will contribute toward a reduced sales charge. The Social Security or account numbers on these accounts are:

**Note:** Investments in the money market fund **do not apply** toward a Class A share Rights of Accumulation.

**C. Automatic exchange plan and rebalance (optional) — requires additional paperwork**

For information on establishing an automatic exchange or rebalance plan prior to opening the account, call us at **(800) 421-4225**. Options added after the account has been established will be considered a change in investment strategy.

## 5 Financial professional/Firm

*If you are affiliated with a broker-dealer firm, provide the information in A. If you are affiliated with a Registered Investment Advisor (RIA) firm, provide the information requested in B.*

**Important:** If a new account owner has been named in **Section 2**, this section must be completed to retain financial professional/firm information.

### A. Financial professional/Broker-dealer firm

We authorize American Funds Service Company® (AFS) to act as our agent for this account and agree to notify AFS of investments made under a Statement of Intention or Rights of Accumulation. If applicable, we have provided a copy of our SEC Form CRS to the account owner named in Section 2.

|                            |                        |               |                           |      |
|----------------------------|------------------------|---------------|---------------------------|------|
| Name(s) of professional(s) | Professional/team ID # | Branch number | (      )<br>Daytime phone | Ext. |
|----------------------------|------------------------|---------------|---------------------------|------|

|                |      |       |     |
|----------------|------|-------|-----|
| Branch address | City | State | ZIP |
|----------------|------|-------|-----|

|   |  |
|---|--|
| Name of broker-dealer firm (as it appears on the Selling Group Agreement) | <b>X</b><br>Signature of person authorized to sign for the broker-dealer — <b>required</b> |
|---|--|

### B. Investment Advisor Representative (IAR)/RIA firm

#### IAR information

|             |                                |
|-------------|--------------------------------|
| Name of IAR | Financial professional number* |
|-------------|--------------------------------|

|  |      |       |     |
|--|------|-------|-----|
| Address (if different from firm address) | City | State | ZIP |
|--|------|-------|-----|

|               |  |      |                 |
|---------------|--|------|-----------------|
| Email address | (      )<br>Daytime phone (if different from firm) | Ext. | (      )<br>Fax |
|---------------|--|------|-----------------|

#### RIA firm information

|   |              |                           |      |
|---|--------------|---------------------------|------|
| Name of RIA firm (as it appears on Form ADV or home office) | Firm number* | (      )<br>Daytime phone | Ext. |
|---|--------------|---------------------------|------|

|              |      |       |     |
|--------------|------|-------|-----|
| Firm address | City | State | ZIP |
|--------------|------|-------|-----|

|                           |                 |                               |
|---------------------------|-----------------|-------------------------------|
| <b>801-</b><br>SEC number | IARD/CRD number | State registration and number |
|---------------------------|-----------------|-------------------------------|

By signing below, I certify that the firm listed above: **1**) has a current Form ADV filed with the U.S. Securities and Exchange Commission or a state regulatory agency; **2**) is providing investment advisory services to the account owner named in Section 2; **3**) if applicable, has provided a copy of SEC Form CRS to the account owner named in Section 2; **4**) indemnifies and holds harmless American Funds Service Company and any of its affiliates or mutual funds managed by such affiliates; and each of their respective directors; trustees; officers; employees; and agents for any losses, expenses, costs or liability (including attorney fees) that may be incurred as a result of misrepresentations or omissions by the firm in connection with the firm making American Funds available to its clients; and **5**) acknowledges and agrees that AFS is not a qualified custodian under the Investment Advisers Act of 1940 Rule 206(4)-2 (the "Custody Rule").

|  |   |   |
|--|---|---|
| <b>X</b><br>Signature of person authorized to sign for the RIA — <b>required</b> | / | / |
|--|---|---|

\* Financial professional number or firm number may be assigned by American Funds. If you are an Investment Advisor Representative (IAR) and need assistance, call **(800) 421-5450**.

## **6 Signature of ABLEAmerica account owner/authorized representative**

*A signature guarantee is required if a new account owner has been named in Section 2.*

I direct AFS to make changes to my ABLEAmerica account in the manner indicated on this form, and I assume sole responsibility for any tax consequences. I certify that the instructions and information provided herein are true and correct.

I hereby establish an ABLEAmerica account with Commonwealth Savers<sup>SM</sup> through American Funds and acknowledge that I have received, read and agree to the terms set forth in the *ABLEAmerica Program Description*, the prospectus(es) of the fund(s) selected and this document, as these documents may be modified from time to time. I understand that I and all shareholders at my address will receive one copy of fund documents (such as annual reports and proxy statements) unless I opt out by calling **(800) 421-4225**. I authorize the instructions set forth in this document.

I acknowledge that I am solely responsible for determining the eligibility of any contributions and for ensuring that total annual contributions (including rollovers) will not exceed the amount established by law for the account owner's ABLEAmerica account. I understand the eligibility requirements for an ABLEAmerica account and affirm that the account owner is an eligible individual as identified in Section 2 of this document.

I agree to hold harmless and indemnify Commonwealth Savers; American Funds Service Company<sup>®</sup> (AFS); any of their affiliates or mutual funds managed by such affiliates; and each of their respective directors; trustees; officers; employees; and agents from any losses, expenses, costs or liability (including attorney fees) that may be incurred in connection with these document instructions, by acting on instructions of the financial professional designated herein, the exercise of the online/telephone investment, exchange and/or withdrawal privileges, or arising from such instructions once the online/telephone exchange and withdrawal privileges have been established, or in connection with the establishment of an account with a minor account owner. I understand that amounts invested may not be withdrawn for 7 business days.

I authorize the financial professional assigned to this account to be my legal representative for purposes of accessing to this account and to act on my behalf with respect to this account, to receive copies of account statements and other documents related to the account and for purposes of confirming contact under state unclaimed property laws. This authorization does not otherwise alter the terms and provisions of the account, and the financial professional agrees to act as my agent. If applicable, I acknowledge that I have received and read a copy of my financial professional's SEC Form CRS.

I understand that this appointment shall survive my incapacity and will remain in effect, and you may rely upon it, until the earlier of **1)** my designation of another financial professional to have access to my account; **2)** my providing you notice of termination as set forth below; or **3)** your receipt of a death certificate verifying my death. I understand that this authorization may be terminated by me at any time by telephone or written notification to AFS. The termination request will be effective as soon as AFS has had reasonable time to act upon it.

I certify that the account owner named in this document is either a U.S. citizen or legal resident. I understand that to comply with federal regulations, information provided on this document will be used to verify my identity. For example, my identity may be verified through the use of a database maintained by a third party. If AFS is unable to verify my identity, I understand it may need to take action, possibly including closing this account and withdrawing the shares at the current market price and that such action may have tax consequences, including a tax penalty.

## 6 Signature of new ABLEAmerica account owner/authorized representative

*A signature guarantee is required if a new account owner has been named in Section 2.*

If this document is signed electronically, I consent to be legally bound by this document and subsequent terms governing it. The electronic copy of this document should be considered equivalent to a printed form in that it is the true, complete, valid, authentic and enforceable record of the document, admissible in judicial or administrative proceedings. I agree not to contest the admissibility or enforceability of the electronically stored copy of this document.

**This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.**

**X** \_\_\_\_\_ / /  
 Signature of current account owner (if authorized to act) \_\_\_\_\_ Date (mm/dd/yyyy)

**X** \_\_\_\_\_ / /  
 Signature of new account owner (if authorized to act) \_\_\_\_\_ Date (mm/dd/yyyy)

**X** \_\_\_\_\_ / /  
 Signature of authorized representative (if applicable) \_\_\_\_\_ Date (mm/dd/yyyy)

**X** \_\_\_\_\_ / /  
 Signature of co-authorized representative (if applicable) \_\_\_\_\_ Date (mm/dd/yyyy)

**If required**, signatures must be guaranteed by a bank, savings association, credit union, member firm of a domestic stock exchange or the Financial Industry Regulatory Authority that is an eligible guarantor institution. **A notary public is NOT an acceptable guarantor.** The guarantee must be in the form of a stamp or a typewritten or handwritten guarantee that is accompanied by a raised corporate seal.

Stamp signature or medallion guarantee here.

Stamp signature or medallion guarantee here.

**If a signature guarantee is required, this form must be mailed.**

ABLEAmerica is a nationwide plan sponsored by  **Commonwealth Savers**

If mailing, choose the service center for your state. Mail the form to the Indiana Service Center if you live outside the U.S.



**American Funds Service Company**  
 P.O. Box 6273  
 Indianapolis, IN 46206-6273

**Overnight mail address**  
 12711 N. Meridian St.  
 Carmel, IN 46032-9181



**American Funds Service Company**  
 P.O. Box 2713  
 Norfolk, VA 23501-2713

**Overnight mail address**  
 5300 Robin Hood Rd.  
 Norfolk, VA 23513-2430

Investor upload [www.capitalgroup.com/submit](http://www.capitalgroup.com/submit)

Financial professional upload [www.capitalgroup.com/upload](http://www.capitalgroup.com/upload)

Fax (888) 421-4351

For more information, contact your financial professional, visit [www.capitalgroup.com](http://www.capitalgroup.com) or call us at (800) 421-4225.