CAPITAL GROUP® | AMERICAN FUNDS®

ABLEAmerica®

ABLE-F-2 Share Account Application

The Achieving a Better Life Experience (ABLE) Act allows eligible individuals with disabilities to invest in a tax-advantaged account created under IRS Section 529A. Earnings are free from federal taxes if withdrawals are used to meet qualified disability expenses. If used for purposes other than qualified disability expenses, earnings are subject to a 10% federal tax penalty. State taxes vary. Withdrawals generally do not count as income for means-tested benefits such as Medicare, Medicaid, and Social Security. Consult your financial professional if you have questions.

Accessing your account online

You will receive a welcome package including your new account number. We encourage you to visit **www.capitalgroup.com/getstarted** to set up online account access once you receive it.

This will enable you to:

- View current and past account balances as well as dividend and capital gain information.
- Manage your account information.
- Sign up for paperless delivery of annual and semiannual reports, quarterly statements and prospectuses.

Fund information

For a quick guide to fund names, numbers, minimums and share class restrictions, go to **www.capitalgroup.com/fundguide**.

Clear and reset form

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ABLE-F-2 Share Account Application

1 Account registration

*The account owner (eligible individual) may only own one ABLE account at a time, except in the case of a transfer or rollover from another ABLE account. Select **A** or **B**.*

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.

Authorized representative(s) — the person(s) who establishes and controls the account on behalf of an account owner.

A. ☐ Account owner — I am an eligible individual who has reached the age of majority and has the capacity to establish and exercise control over an ABLEAmerica account.

B. ☐ Authorized representative (select 1 or 2):

Important: By completing this Section 1-B and signing in Section 10, you certify under penalty of perjury that:

1. ☐ You are authorized under a power of attorney or other legally binding document executed by the account owner (eligible individual) that permits you to establish and exercise control over an ABLEAmerica account for the benefit of the account owner.

2. ☐ **1)** The account owner lacks legal capacity to establish and exercise control over his or her own ABLEAmerica account; **2)** there is no other person with a higher priority under the following hierarchy to establish and exercise control over an ABLEAmerica account for the benefit of the account owner: a person selected by the account owner, or the account owner's agent under a power of attorney, conservator or legal guardian with authority to make financial decisions for the account owner, spouse, parent, sibling, grandparent of the account owner, in that order; and **3)** you have authority to establish and exercise control over an ABLEAmerica account for the benefit of the account owner.

Further, **1)** you agree to administer the ABLEAmerica account for the benefit of the account owner; **2)** you agree to notify ABLEAmerica if the certification above ceases to be true; and **3)** you understand that at any time, an account owner with legal capacity may remove you as an authorized representative.

2 Account owner information

☐☐☐–☐☐–☐☐☐☐ SSN of account owner

☐☐–☐☐–☐☐☐☐ Date of birth of account owner (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

*Your privacy is important to us. For information on our privacy policies, visit **www.capitalgroup.com**.

3 Authorized representative information — if applicable

*Complete **A**, **B** and **C** as applicable.*

A. ☐☐☐–☐☐–☐☐☐☐ ☐☐–☐☐–☐☐☐☐ _____

SSN of authorized representative | Date of birth of authorized representative (mm/dd/yyyy) | Country of citizenship

_____ _____ _____

First name of authorized representative | 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

*Your privacy is important to us. For information on our privacy policies, visit **www.capitalgroup.com**.

B. Additional authorized representative information — if applicable

Complete this section to add a second authorized representative who is authorized to establish and exercise control of an ABLEAmerica account for benefit of the account owner. All authorized representatives must sign this application.

☐☐☐–☐☐–☐☐☐☐ ☐☐–☐☐–☐☐☐☐ _____

SSN of authorized representative | Date of birth of authorized representative (mm/dd/yyyy) | Country of citizenship

_____ _____ _____

First name of authorized representative | 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

*Your privacy is important to us. For information on our privacy policies, visit **www.capitalgroup.com**.

C. Authority of authorized representatives to act — if applicable

If two authorized representatives are named, select one:

☐ Authorized representatives may act independently. If a financial or account maintenance request must be submitted in writing, **only one** authorized representative signature is needed.

OR

☐ Authorized representatives must act jointly†. If a financial or account maintenance request must be submitted in writing, **all** authorized representatives must sign.

Note: If no selection is made, authorized representatives may act independently.

†Requests that can be made via phone only require one authorized representative to act.

4 Successor owner or successor authorized representative information — if applicable

A. 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) ☐☐–☐☐–☐☐☐☐

B. Successor authorized representative designation

The successor authorized representative(s) becomes the authorized representative upon the death or incapacity of all authorized representatives and must meet the ordering rules outlined in Section 1-B-2 of this application. If two successor authorized representatives are listed, they shall be co-authorized representatives.

First name of authorized representative _____ MI _____ Last _____

SSN of authorized representative ☐☐☐–☐☐–☐☐☐☐ Date of birth of authorized representative (mm/dd/yyyy) ☐☐–☐☐–☐☐☐☐

First name of authorized representative _____ MI _____ Last _____

SSN of authorized representative ☐☐☐–☐☐–☐☐☐☐ Date of birth of successor authorized representative (mm/dd/yyyy) ☐☐–☐☐–☐☐☐☐

C. Authority of successor authorized representatives to act — if applicable

If two successor authorized representatives are named, select one:

☐ Successor authorized representatives may act independently. If a financial or account maintenance request must be submitted in writing, **only one** successor authorized representative signature is needed.

OR

☐ Successor authorized representatives must act jointly.* If a financial or account maintenance request must be submitted in writing, **all** successor authorized representatives must sign.

Note: If no selection is made, successor authorized representatives may act independently.

*Requests that can be made via phone only require one successor authorized representative to act.

5 Account owner eligibility

*This information will be used for tax reporting purposes. You must complete **A**, **B** and **C**.*

By completing this section and signing in Section 10, you certify under penalties of perjury that: **1)** The codes checked in A and B below are correct; **2)** the account owner developed the disability or blindness before the age of 26; **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.

A. 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 **1)** blind (within the meaning of the Social Security Act); **2)** 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 **3)** 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 application, but you must retain and provide a copy to ABLEAmerica or the IRS upon request.

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

- ☐ Code 1 — Developmental disorder
- ☐ Code 2 — Intellectual disability
- ☐ Code 3 — Psychiatric disorder
- ☐ Code 4 — Nervous disorder
- ☐ Code 5 — Congenital anomaly
- ☐ Code 6 — Respiratory disorder
- ☐ Code 7 — Other (any other disability not listed under Codes 1 to 6)

C. Is the disability permanent? ☐ Yes ☐ No

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

6 Investment instructions

*You must complete **A** and **B**.*

Please review ABLEAmerica maximum contribution and transfer/rollover limits prior to completing this section.

A. Indicate your contribution method. Select all that apply, and **provide your investment selection(s) in 6-B**.

1. ☐ **Check** — made payable to "ABLEAmerica"
2. ☐ **Bank account** — Provide bank information in Section 7.

Important note: Bank account investments may not be available in all circumstances. Before selecting the contribution method(s) below, contact us for eligibility restrictions.

☐ **One-time investment** — The transaction will be processed on the same day the account is established.

Amount: $ _____

AND/OR

Continued on next page

6 Investment instructions

(continued)

☐ **Automatic investment plan:**

Notes:

- American Funds must receive your request at least five business days prior to the first transaction date requested. If no date is provided below, the automatic plan will be established on the date received. Transactions will begin the following month and will occur monthly thereafter.
- Provide bank information in Section 7.

Transactions should begin during the month of _____

Transactions should occur on the following date(s) of the month _____, _____ (e.g., 8th, 19th)

Frequency: ☐ Monthly ☐ Every other month ☐ Quarterly ☐ Annually

3. ☐ **Direct transfer/rollover:** The account is being funded via a direct transfer/rollover from a non-American Funds ABLE plan or a 529 plan.* You must submit an *ABLEAmerica Rollover/Transfer Request* with this application.

4. ☐ **Indirect rollover:** The account is being funded with assets that have been withdrawn from a non-American Funds ABLE plan or a 529 plan.* Include a personal check made payable to **"ABLEAmerica"** for the amount of the rollover.

   Indirect rollovers between ABLE accounts for the same beneficiary can only be completed once every 12 months. The prior ABLE account must be closed and the rollover must be deposited into the new ABLE account within 60 days of the withdrawal.

5. ☐ **Account will be funded later.**

*American Funds must receive a statement from your prior institution showing basis and earnings of the funds being transferred/rolled over. If American Funds does not receive this documentation, the entire amount will be treated as earnings in computing the earnings portion of any future withdrawal from the account. Please refer to the ABLEAmerica Program Description for more information.

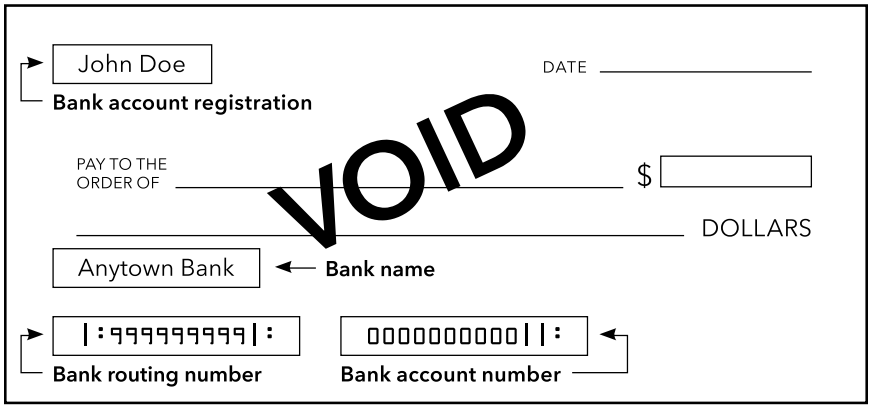
B. Provide investment selection(s) below.

Fund name	One-time investment Amount		One-time investment Percentage	Automatic investment plan ($50 min. per fund)
American Funds Global Growth Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds Growth Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds Growth and Income Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds Moderate Growth and Income Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds Conservative Growth and Income Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds Preservation Portfolio	$ _____	**OR**	_____ %	$ _____
American Funds U.S. Government Money Market Fund	$ _____	**OR**	_____ %	$ _____
Total	**$** _____	**OR**	_____ **%**	**$** _____

7 Bank information

A. Tape an unsigned, voided check below (no deposit slips) — In lieu of a check, submit a letter on your bank's letterhead providing the bank information.

Tape your check here.



B. Link my bank information:

Important note: These options may not be available in all circumstances. Before selecting bank account option(s) below, contact us for eligibility restrictions and requirements.

☐ For online/telephone investing ☐ For online/telephone withdrawals from my American Funds account

Note: If no option is selected, your bank account will be linked for investing and withdrawals.

C. Signature guarantee requirements:

1. For investing (ACH):

Is the ABLEAmerica account owner listed as a bank account owner?

☐ Yes. **Proceed to Section 7-C-2.**

☐ No — **The signature of the bank account owner(s) must be guaranteed.** Obtain and submit the *Add/Update Bank Information* form to add the ACH option.

2. For withdrawals from my ABLEAmerica account (ACH):

Is the ABLEAmerica account owner listed as a bank account owner?

☐ Yes. **Proceed to Section 7-D.**

☐ No — **The signature of the authorized representative or account owner (if authorized to act) must be guaranteed.** Obtain and submit the *Add/Update Bank Information* form to add the ACH option.

D. Are you signing this form electronically?

☐ No. **Proceed to Section 8.**

☐ Yes — Complete the following bank information **ONLY** if your financial professional's firm has an electronic signature indemnification agreement with American Funds.

Bank name _____ Bank routing number _____

☐ Checking **OR** ☐ Savings

Bank account number _____ Bank account owner(s) _____

Notes:

- Once the withdrawal option is established, there will be a 10-day waiting period before it can be used. The investment option is available once the account has been established.
- Your election will apply to all of your current and future accounts. You may cancel the options at any time by calling us at **(800) 421-4225**.

8 Additional options

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 or rebalance plan at the time of account setup. Adding or changing an automatic exchange or rebalance plan 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.

B. Automatic exchange or rebalance plans (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, ext. 529**. Options added after the account has been established will be considered a change in investment strategy.

C. Household account aggregation

Account owner, spouse and children under 21 or disabled adult children with ABLE accounts can aggregate accounts. Any share classes within these accounts may contribute toward reduced fees. The Social Security or account numbers on these accounts are:

_____ _____ _____

9 Financial professional

Important: *This section must be signed by an individual authorized to act on behalf of the firm.*

Note: We do not offer fee debiting for ABLE-F-2 share accounts.

Financial professional information

Name of financial professional

Financial professional number*

Address (if different from firm address)

City

State

ZIP

Email address

( ) Ext.
Daytime phone (if different from firm)

( )
Fax

Firm information

Name of firm (as it appears on Form ADV or home office)

Firm number*

( ) Ext.
Daytime phone

Firm address

City

State

ZIP

801-

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; **3)** if applicable, has provided the account owner named on this application a copy of SEC Form CRS; **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").

X

Signature of person authorized to sign on behalf of firm — **required**

/ /
Date (mm/dd/yyyy)

*Financial professional number or firm number may be assigned by American Funds. If you need assistance, call **(800) 421-5450**.

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

Financial professional upload www.capitalgroup.com/upload

Fax (888) 421-4351

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

10 Signature

All individuals with legal capacity to act on the account must sign this section.

I hereby establish an ABLEAmerica account with Commonwealth Savers 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 application, 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, ext. 529**. I authorize the instructions set forth in this application.

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 5 of this application.

I agree to hold harmless and indemnify Commonwealth Savers; American Funds Service Company (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 application instructions, by acting on instructions of the financial professional designated herein, the exercise of the telephone or website 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.

If I have requested ACH privileges, I authorize AFS, upon request via phone, fax or any other means utilizing telecommunications, including wireless or any other type of communication lines by authorized persons with appropriate account information, to **1)** withdraw fund shares from this account and deposit the proceeds into the bank account identified on this application; and/or **2)** secure payments from the bank account into this account. I authorize the bank to accept any such credit or debit to this account without responsibility for its correctness.

I authorize the financial professional assigned to this account to be my legal representative for purposes of accessing 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 and the authorized representative (if applicable) named in this application are either U.S. citizens or legal residents. I understand that to comply with federal regulations, information provided on this application 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.

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. A copy of this document will be made available to me as required.

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

X _____ / / _____

Signature of account owner (if authorized to act) Date (mm/dd/yyyy)

X _____ / / _____

Signature of authorized representative Date (mm/dd/yyyy)

X _____ / / _____

Signature of authorized representative (if applicable) Date (mm/dd/yyyy)

CGD/10126-S102566

Lit. No. MFGEFM-140-0525O