

# ACCOUNT APPLICATION

**INSTRUCTIONS:** The ABLE Account Owner is the disabled individual who is to benefit from the LA ABLE Account. If the Account Owner is capable of handling his own affairs, he is both the Account Owner and the Account Administrator. If the Account Owner is not capable of completing this agreement due to age, disability, or other legal impediment, an Account Administrator may complete this agreement on his behalf. This completed application should be mailed to the Louisiana ABLE Account Program, P.O. Box 91008, Baton Rouge, LA 70821-9008, or by completing the on-line version at [www.able.osfa.la.gov](http://www.able.osfa.la.gov). If you submit this paper application, you should include a check or money order for at least \$10 payable to "LA ABLE" with your application. Your first deposit must be at least \$10 and must be made within 180 days from the date on the letter of notification of approval of the account. **Type or print in ink.**

## Section A: ACCOUNT OWNER INFORMATION:

1. Check one:  Mr.  Mrs.  Ms.  
Last Name First Name MI Suffix

*(Name must be exactly as recorded on your social security card)*

2. Social Security Number:

3. Date of Birth (MM/DD/YYYY):

4. Permanent Mailing Address: Number and Street (including Apartment Number)

City:

State:

Zip Code:

5. Are you a U.S. Citizen or Permanent Resident?

Yes  No

6. E-mail Address:

CONTACT **LA ABLE**



Visit [able.osfa.la.gov](http://able.osfa.la.gov)



Email [laable@la.gov](mailto:laable@la.gov)



Call 800.259.5626  
Fax 225.612.6497



P.O. Box 91008  
Baton Rouge, LA 70821-9008

7. Telephone Number:

8. Alternate Telephone Number:

9. The Account Owner is a Permanent Resident of What State?

Parish/County

**Section B: BASIS OF ACCOUNT OWNER'S ELIGIBILITY** Please select one of the following options which best describes the basis of the Account Owner's eligibility to open a Louisiana 529A ABLÉ Account. Note that in all instances, the onset of the disability must have developed before age 26.

10. Eligibility Basis: Please check one:

- Code A - Eligibility Established under IRC 529A(e)(1) (A), SSDI, Title II SSA
- Code B - Eligibility Established under IRC 529A(e)(1) (A), SSI, Title XVI SSA
- Code C - Designated beneficiary has a signed physician's diagnosis which will be provided to the LA ABLÉ Program and/or the IRS upon request.

**Section C: ACCOUNT OWNER'S TYPE OF DISABILITY** Please select one of the following options which best describes the Account Owner's type of disability. This information will only be used for reporting purposes as required by law. Please check only one primary code for the type of disability for which the Account Owner is eligible to open an ABLÉ Account. If more than one code applies, select the most significant code.

11. Type of Disability: Please check one:

- Code 1 - Developmental Disorders: (including Autism) Autistic Spectrum disorder; Asperger's Disorder, Developmental Delays and Learning Disabilities
- Code 2 - Intellectual Disability: May be reported as mild, moderate, or severe intellectual disability.
- Code 3 - Psychiatric Disorders: schizophrenia; Major depressive disorder; Post-traumatic stress disorder (PTSD); Anorexia nervosa; Attention deficit/hyperactivity disorder (AD/HD); Bipolar disorder.
- Code 4 - Nervous Disorders: Blindness, Deafness; Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease; Multiple sclerosis; Severe hearing loss; Congenital cataracts.
- Code 5 - Congenital Anomalies: Chromosomal abnormalities including Down Syndrome, Osteogenesis Imperfecta; Xeroderma pigmentosum; Spinal muscular atrophy; Fragile X syndrome; Edwards syndrome.
- Code 6 - Respiratory Disorders: Cystic Fibrosis
- Code 7 - Other

**Section D: ACCOUNT ADMINISTRATOR INFORMATION.** The Account Administrator may be the Account Owner or a person legally authorized to act on behalf of the Account Owner.

12. Check one:  Mr.       Mrs.       Ms.  
Last Name:                                  First Name                                  MI:                                  Suffix:

*(Name must be exactly as recorded on your social security card)*

13. Permanent Mailing Address:

City                                  State                                  Zip Code

14. Social Security Number:

15. Date of Birth (MM/DD/YYYY):

16. The Account Administrator is a Permanent Resident of What State?                  Parish/County

17. E-mail Address:

18. Telephone Number:

19. Alternate Telephone Number:

20. How would the Account Administrator like to receive notifications regarding the Account?

Electronic Notifications (by email)

Postal Notifications (by mail)

21. As the Account Administrator, you are required to certify, under penalty of perjury, that the person for whom the account is being opened is an eligible individual and you are the highest ranked individual eligible to administer an ABLÉ account. You will be required to recertify that the eligible individual remains an eligible individual as well as your position in the hierarchy annually. Please select one of the following for the account hierarchy:

1. Self (When the Account Owner is the same person as the Account Administrator and administers their own account)

- 2. A person selected by the eligible individual or by an agent appointed by the eligible individual;
- 3. A custodian appointed by a court of law or a legal guardian;
- 4. The spouse of the eligible individual;
- 5. A parent of the eligible individual;
- 6. A sibling of the eligible individual;
- 7. A grandparent of the eligible individual;
- 8. A representative payee appointed by the SSA

**Section E: DESIGNATE A SUCCESSOR ADMINISTRATOR** In the event of the Account Administrator's death, the following named person is to be the account administrator.

**21.** Check one:     Mr.          Mrs.          Ms.  
                         Last Name                                      First Name                                      MI                                      Suffix

*(Name must be exactly as recorded on your social security card)*

**22.** Permanent Mailing Address:

City:                                      State:                                      Zip Code:

**23.** Social Security Number:

**24.** Date of Birth (MM/DD/YYYY):

**25.** E-mail Address:

**26.** The Account Administrator is a Permanent Resident of What State?         Parish/County

**27.** Telephone Number:

**28.** Alternate Telephone Number:

**Section F: SELECT A METHOD OF MAKING DEPOSITS:** Mark all options that may apply.

29.  Electronic Funds Transfer from Owner's Account

(Form can be downloaded at [www.able.osfa.la.gov](http://www.able.osfa.la.gov))

Direct Payments (Mail deposits to the LA ABLE Account Program, See Address on Page 1)

If you have chosen Electronic Funds Transfer, complete the Louisiana ABLE Authorization for Automatic Debits from a Personal Bank Account form. To activate your account, send a check or money order payable to "LA ABLE".

**Section G: SELECT INVESTMENT(S) FUNDS:** Investment funds and any applicable fees are fully explained in the ABLE Disclosure Booklet available upon request from the Louisiana ABLE Program or on our Web site at [www.able.osfa.la.gov](http://www.able.osfa.la.gov). You must thoroughly review the ABLE Disclosure Booklet prior to selecting your investment fund. In accordance with federal regulations, the investment fund(s) for future deposits may be selected at the time of the deposit, but the investment fund(s) for monies in an existing account may be changed only twice per calendar year. Choose the fund(s) in which your deposits will be placed. If more than one fund is selected, indicate the percentage of the deposit for each fund. The percentage must be a whole number (Examples: 10,15, 25, etc.) and the total percentage for all funds must total 100%.

30. Investment Funds

Vanguard Federal Money Market Fund (VMFXX)	____%
Vanguard Short-Term Bond Index Fund Admiral Shares (VBIRX)	____%
Vanguard Intermediate-Term Bond Index Fund Admiral Shares (VBILX)	____%
Vanguard LifeStrategy® Growth Fund (VASGX)	____%
Vanguard LifeStrategy® Moderate Growth Fund (VSMGX)	____%
Vanguard LifeStrategy® Conservative Growth Fund (VSCGX)	____%
Vanguard LifeStrategy® Income Fund (VASIX)	____%
Vanguard Total Stock Market Index Fund (VITPX)	____%
Vanguard Total International Stock Index Fund (VTSNX)	____%
Vanguard Institutional Index Fund-Institutional Shares (VINIX)	____%
Vanguard Value Index Fund - Institutional Shares (VIVIX)	____%
Vanguard Growth Index Fund - Institutional Shares (VIGIX)	____%

Total \_\_\_\_%  
**(Must equal 100%)**

**Section H: DISBURSEMENT OF FUNDS AFTER FINAL EXPENSES PAID:** Upon the death of the Account Owner and after final expenses have been paid, the funds remaining should be disbursed to:

Check Only One:

- Disabled sibling of the named Account Owner:

Sibling Name: \_\_\_\_\_

Sibling Date of Birth: \_\_\_\_\_

Sibling Social Security Number: \_\_\_\_\_

Sibling Physical Address: \_\_\_\_\_

Sibling Phone Number: \_\_\_\_\_

Sibling E-mail Address: \_\_\_\_\_

- The estate of the named Account Owner

**Section I: OPTIONAL RESPONSES:** The following questions are OPTIONAL. They will assist the administering agency in statistical analysis and will not be used for any other purpose.

**31.** How did you first hear of the ABLE Program?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> TV                  | <input type="checkbox"/> Radio Newspaper | <input type="checkbox"/> ABLE/LOSFA Publication |
| <input type="checkbox"/> Other Publication   | <input type="checkbox"/> School Contact  | <input type="checkbox"/> Day Care/Nursery       |
| <input type="checkbox"/> Hospital/Dr. Office | <input type="checkbox"/> Word of Mouth   | <input type="checkbox"/> Financial Institution  |
| <input type="checkbox"/> Other               |  |   |

**32.** Account Owner's Ethnicity:

(Mark Only One) :  Hispanic or Latino  Not Hispanic or Latino

Race: (Mark all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Multiracial
- White

## Section J: GOVERNING LAWS AND NOTICES & ACCOUNT OWNER'S CERTIFICATION

The terms of the Participation Agreement will be interpreted in accordance with applicable federal and state law and the Louisiana Tuition Trust Authority (LATTA) rules and regulations. If any provision of the Agreement is determined to be unenforceable, the remaining provisions shall remain in full force and effect. I understand and agree that: If the funds are not used to meet the Qualified Disability Expenses of the Account Owner, there may be tax consequences; the assets of the LATTA reserved for payment of the obligations of the LATTA with respect to the LA ABLÉ Account Program pursuant to the Participation Agreement shall be placed in a special fund in the state Treasury for LA ABLÉ Account Program accounts; any claim filed by or on behalf of an Account Owner against the LATTA pursuant to the Participation Agreement shall be made solely against the Account Owner's portion of the assets of this fund; no Account Owner of a LA ABLÉ account shall have any claim against the State General Fund or other funds or revenues of the State of Louisiana; the LATTA does not guarantee any investment in equities; the LATTA reserves the right to amend the rules regulating the LA ABLÉ Account Program in accordance with the Louisiana Administrative Procedure Act; any amendments to applicable state or federal statutes and/or regulations shall automatically amend the terms and conditions of the Participation Agreement; and any notice required to be given to the Account Owner will be effective if mailed by first class mail (or e-mail if I have opted for electronic correspondence) to the latest address I have provided LATTA.

### Account Owner's Certification and Authorization

I, meaning the Account Administrator named in Section D, certify that I am of full legal age and that the information I have provided in this Application is true, complete and correct to the best of my knowledge and belief and is made in good faith. I agree to be bound by the statutes, regulations and rules governing the LA ABLÉ Account Program. I have read and understand the LA ABLÉ Account Program Disclosure Booklet and the terms and conditions incorporated into the Account Participation Agreement. I certify that if I am not the account owner named in Section A, I am legally authorized to act on behalf of the account owner. I further authorize the LATTA to release information pertaining to this agreement but only to those agencies or individuals that the LATTA determines to be essential to effectuate the purpose of this agreement.

Account Administrator: \_\_\_\_\_  
(Print Name)

Account Administrator: \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

**OFFICE USE ONLY:** Account Number Assigned: \_\_\_\_\_ Date: \_\_\_\_\_

CONNECT WITH LA ABLÉ

