ABLE | NATIONAL RESOURCE CENTER

Save Today, Enjoy Tomorrow

Secure Your Financial Future with an ABLE Account

An ABLE account can help you manage your money and plan for the future. ABLE accounts are special savings accounts for people with disabilities. Whether you are saving for future goals or paying for today's needs, an ABLE account gives you that flexibility.

An ABLE account allows individuals with disabilities, their families and those who support them to contribute up to $19,000[1] annually.

Save Smart with ABLE: Protect your benefits now and in the future

(Many accounts offer investment options!)

Supplemental Security Income (SSI) does not count up to $100,000 in an ABLE account, so you can save money without affecting this benefit. ABLE account owners can save up to their state plan limits which can range from $238,000 to $596,000.[2]

ABLE savings do not affect other benefits like FAFSA, HUD, Medicaid, Medicare, SNAP or Social Security Disability Insurance (SSDI). Interest in the ABLE account and ABLE investment growth is not counted as income and is not taxable.

Benefits of Opening an ABLE Account

- *An account for saving and investing.*
- *ABLE contributions from friends and family are not counted as income.*
- *Investment growth is tax-free.*
- *Employed ABLE account owners may have even more advantages.[3]*
- *Savings may be used as needed.*

1 Note that the $19,000 annual contribution amount may change each year. Current ABLE Account Contribution Limits - ABLE National Resource Center (ablenrc.org)

2 Subject to change

3 ABLE to Work Act - ABLE National Resource Center (ablenrc.org)

Alltrust Payee Corp., Inc

REQUEST TO ESTABLISH AN ABLE ACCOUNT

FLORIDA ABLE ACCOUNT – BENEFICIARY APPLICATION FORM

Section 1 – Beneficiary Information

- **Full Legal Name:** _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Social Security Number:** _____
- **Residential Address:** _____
  City: _____ State: FL ZIP: _____
- **Phone Number:** _____
- **Email Address:** _____

Section 2 – Eligibility Certification

I certify that:

☐ I am a Florida resident.

☐ I have a qualifying disability that began before age 46

☐ I meet one of the following:

- Receiving SSI or SSDI benefits, **OR**
- Have a signed disability certification from a licensed physician.

Type of Disability: _____

Onset Age: _____

Section 3 – Authorized Individual (If Applicable)

- **ALLTRUST PAYEE CORP., INC**
- **PO BOX 650369**
- **VERO BEACH, FL 32965**
- **772-226-0165**____admin@alltrustpayee.com_____
- **Relationship to Beneficiary: _ORGANIZATIONAL REPRESENTATIVE PAYEE**

_____ _____

Beneficiary Signature Date

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION: ** PHONE NUMBER OF PERSON OR ORGANIZATION:
ALLTRUST PAYEE CORP, INC.	PO BOX 350369
	VERO BEACH, FL 32965-0369
	772-226-0165

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☐ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   DPQY

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address (Number and street,City,State, and ZIP Code)	Address (Number and street,City,State, and ZIP Code)