Clear and reset form

CAPITAL GROUP® | AMERICAN FUNDS®

ABLEAmerica®

Authorized Representative/ Successor Authorized Representative Change Request

- Use this form when requesting a change of authorized representative or successor authorized representative on your ABLEAmerica account.
- If the authorized representative 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 authorized representative

First name of current authorized representative | MI | Last | ( ) Daytime phone

Address | City | State | ZIP

Name of current account owner | Account number

2 Authorized representative change — if applicable

*Complete **A** through **E** as applicable.* ***The authorized representative(s) named in this section will replace any existing authorized representative(s) listed on the account. You must specify all authorized representatives on this form even if you are adding or updating one authorized representative. A signature guarantee is required.***

A. Authorized representative relationship to account (Select 1 or 2):

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

Important: By completing this section and signing in Section 6, 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.

OR

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.

B. New authorized representative information

☐☐☐–☐☐–☐☐☐☐ SSN | ☐☐–☐☐–☐☐☐☐ Date of birth (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**.

Continued on next page

2 Authorized representative change — if applicable

(continued)

C. Additional authorized representative relationship to account — if applicable (Select 1 or 2)**:**

Important: By completing this section and signing in Section 6, 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.

OR

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.

D. Additional authorized representative Information — if applicable

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

☐☐☐–☐☐–☐☐☐☐ 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**.

E. 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.

3 Successor authorized representative change — if applicable

*Complete **A** and **B**. **The successor authorized representative(s) named in this section will replace any existing successor authorized representative(s) listed on the account. You must specify all successor authorized representatives on this form even if you are adding or updating one successor authorized representative.***

A. New successor authorized representative designation

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

First name of authorized representative _____ MI _____ Last _____ Date of birth of successor authorized representative (mm/dd/yyyy) ☐☐–☐☐–☐☐☐☐

First name of authorized representative _____ MI _____ Last _____ Date of birth of successor authorized representative (mm/dd/yyyy) ☐☐–☐☐–☐☐☐☐

B. Authority of new 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.

4 Additional options — if applicable

If a new authorized representative 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 authorized representative 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 authorized representative named in Section 2.

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

Branch address | City | State | ZIP

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

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

RIA firm information

Name of RIA 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 authorized representative named in Section 2; **3)** if applicable, has provided a copy of SEC Form CRS to the authorized representative 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").

X Signature of person authorized to sign for the RIA — **required** | Date (mm/dd/yyyy)

*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 changing an authorized representative(s) in Section 2.

I direct AFS to make changes to the 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 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.

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 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 and the authorized representative (if applicable) named in this document are either U.S. citizens or legal residents. 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.

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6 Signature of ABLEAmerica account owner/authorized representative

A signature guarantee is required if changing an authorized representative(s) 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 _____ Date ___/___/___ (mm/dd/yyyy)
Signature of account owner (if authorized to act)

X _____ Date ___/___/___ (mm/dd/yyyy)
Signature of current authorized representative

X _____ Date ___/___/___ (mm/dd/yyyy)
Signature of current authorized representative (if applicable)

X _____ Date ___/___/___ (mm/dd/yyyy)
Signature of new authorized representative

X _____ Date ___/___/___ (mm/dd/yyyy)
Signature of new authorized representative (if applicable)

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 | **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.

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