Maryland529

Maryland Prepaid College Trust (MPCT)
Refund Request Form

Upload to: ***maryland529.com/prepaid-login***

IMPORTANT UPDATE
Click here for important information from Maryland529 which may impact your refund value.

- Use this form to request a refund for:
  - » Voluntary Cancellation or Non-Qualified Educational Expenses.
  - » Excess Benefits (including Scholarship, Grant, or Military Academy refunds).
  - » Indirect Rollover to another Qualified Tuition Plan (QTP).
  - » Death or Disability of the Beneficiary.
- Please consult an independent tax professional regarding the applicability of federal, state, and local tax law to your circumstances before submitting your refund request.
- Indicates a Signature Guarantee is required. Refund requests of **$25,000** or more will require a Signature Guarantee to be considered in good order.
- Indicates additional documentation is required.
- **Note:** Failure to provide required information may result in a delay of processing your request.
- Complete a separate form for each Account, and upload by logging in to **maryland529.com/prepaid-login**.

1. ACCOUNT INFORMATION *(required)*

Account Number

Account Holder, Custodian, or Entity Representative Name *(first, MI, last)*

Daytime Phone Number

Beneficiary Name *(first, MI, last)*

2. REFUND TYPE

Prior to completing this form, please review details on refunds that are contained in the Disclosure Statement, in Article VI – Termination, Transfer and Refund. The $75.00 cancellation fee will be deducted from your refund prior to it being issued. The $75.00 cancellation fee is waived when the refund request is for Excess Benefits and/or Scholarship/Grant/Military Academy Coverage.

Your request may require additional documentation as outlined below:

- The **death** of the Beneficiary - please attach a copy of the death certificate .
- The **disability** of the Beneficiary (as defined in the MPCT Disclosure Statement under Disabled or Disability) - please have physician complete Section 7 or attach medical documentation .
- **Excess Benefits** beyond the Benefit Claim maximum for a given semester/year to include:
  - » **Scholarship/Grant/Military Academy Coverage** – Please attach proof of scholarship coverage for tuition and/or fees.
  - » **Excess Benefits** – Please attach documentation showing the Qualified Higher Education Expenses for which you are requesting the Excess Benefit refund.
    - **Did you know?** If your request is less than or equal to the semester maximum for expenses billed along with Tuition and Fees, you may submit a Benefit Claim request online for Excess Benefits. This form may then be submitted for Excess Benefits in addition to the semester maximum. Login at **maryland529.com/prepaid-login** to see if your request may be submitted as a Benefit Claim.

Select **one** of the following:

- ◯ **Voluntary Cancellation** for any benefits to be used for Non-Qualified Expenses.
- ◯ Excess Benefits due to **Scholarship/Grant/Military Academy Coverage.**
- ◯ **Excess Benefits** for other Qualified Higher Education Expenses.
- ◯ **Indirect Rollover** to transfer to another Qualified Tuition Program within 60 days.
- ◯ **Death or Disability** of the Beneficiary (Full Refunds ONLY).

3. REFUND AMOUNT

Indicate below whether you are requesting a full or partial refund:

◯ **Full** Refund

◯ **Partial** Refund

Partial Refund Amount

4. REFUND PAYEE

The refund will be issued to the address on record for the payee within five to ten business days of the processing of a refund request in good order. Please select a payee below to receive the refund and the associated tax reporting:

◯ **Account Holder**

◯ **Beneficiary**

5. ACCOUNT HOLDER'S SIGNATURE

By signing below, I agree to the terms and conditions set forth below and in the MPCT Disclosure Statement. I understand and agree that these documents govern all aspects of this Account and are incorporated herein by reference.

I certify that I am the Account Holder, or I have the authority to act on behalf of the Account Holder, and additionally that:

It is my intent to request a refund from my MPCT Account and I authorize Maryland529, MPCT, its agents and their affiliates to act on my instructions based upon this information. I understand that there may be tax penalties associated with my request and that I am solely responsible for the tax repercussions of this request. All of the information provided by me on this form is, and all information provided by me in the future will be, true, complete and correct. I understand that the MPCT Disclosure Statement may be amended from time to time and I understand and agree that I will be subject to the terms of those amendments. If I am issuing instructions for an Account in a representative capacity (e.g., as a Trustee of a Trust or pursuant to a Power of Attorney), I understand and acknowledge that I am assuming any responsibility for any adverse consequences resulting from my instructions. I further agree that neither Maryland529, MPCT, nor its agents will be liable for any loss, liability, cost or expense for acting upon these instructions, except to the extent required by applicable law.

Signature of Account Holder, Custodian, or Authorized Representative

Date *(mm/dd/yyyy)*

6. SIGNATURE GUARANTEE

All refund requests of **$25,000** or more will require a Signature Guarantee to be considered in good order. Authorized officers of certain commercial banks, trust companies, savings associations, credit unions and members of the United States stock exchange may provide a signature guarantee. A notary public cannot provide a medallion signature guarantee. Do not sign below until you are in the presence of the authorized officer providing the signature guarantee.

I certify that the information provided herein is true and complete in all respects.

Signature of Account Holder

Date *(mm/dd/yyyy)*

Title / Name of Institution

Authorized Officer to Place Stamp Here

See next page for Section 7

7. PHYSICIANS DISABILITY CERTIFICATION *(Disability Refunds Only)*

Provide this section to the Beneficiary's Physician if you are requesting a Disability Refund of your MPCT Account.

Physician's Name *(first, MI, last)*

Street Address Line 1

Street Address Line 2

City

State

ZIP Code

Business Phone

- I am a Doctor of Medicine/Osteopathy and am legally authorized to practice in the State of _____
  State

  under my professional license number: _____.
  State License Number

- I am the Beneficiary's Physician and am certifying that _____ has a disability, a condition
  Beneficiary Name

  which makes them unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

I hereby certify that all of the information provided by me on this form is, and all information provided by me in the future will be, true, complete and correct.

Signature of Physician

Date *(mm/dd/yyyy)*