STATE FARM FUNDS
COVERDELL EDUCATION SAVINGS ACCOUNT APPLICATION

For assistance in completing this application, please contact us at 800–447-0740. Please fax or mail your completed, signed and dated application to: State Farm Funds, P.O. Box 4766, Chicago, IL 60680-4766. Overnight: State Farm Funds c/o Northern Trust, Attn: Funds Center, 333 S Wabash W-38, Chicago IL 60604. Fax: 312-557-3093.

Please print all information.

1 PROVIDE YOUR INVESTOR INFORMATION

DESIGNATED BENEFICIARY (CHILD FOR WHOM THE ACCOUNT IS BEING ESTABLISHED)

DESIGNATED BENEFICIARY'S FIRST NAME | MIDDLE INITIAL | LAST NAME

DESIGNATED BENEFICIARY'S SOCIAL SECURITY NUMBER (WILL BE USED FOR TAX REPORTING) | DATE OF BIRTH

RESIDENTIAL/STREET ADDRESS

RESIDENTIAL/STREET ADDRESS

CITY/STATE/ZIP

DEPOSITOR (THE INDIVIDUAL MAKING THE CONTRIBUTION, IF DIFFERENT FROM THE RESPONSIBLE INDIVIDUAL)

DEPOSITOR'S FIRST NAME | MIDDLE INITIAL | LAST NAME

DEPOSITOR'S SOCIAL SECURITY NUMBER | DATE OF BIRTH

RESIDENTIAL/STREET ADDRESS

RESIDENTIAL/STREET ADDRESS

CITY/STATE/ZIP

RESPONSIBLE INDIVIDUAL (PARENT OR LEGAL GUARDIAN WHO IS AUTHORIZED TO ACT ON THE ACCOUNT)

RESPONSIBLE INDIVIDUAL'S FIRST NAME | MIDDLE INITIAL | LAST NAME

RESPONSIBLE INDIVIDUAL'S SOCIAL SECURITY NUMBER | DATE OF BIRTH | MOTHER'S MAIDEN NAME

RESIDENTIAL/STREET ADDRESS

RESIDENTIAL/STREET ADDRESS

CITY/STATE/ZIP

TELEPHONE NUMBER (DAYTIME) | TELEPHONE NUMBER (EVENING)

E-MAIL ADDRESS

1 PROVIDE YOUR INVESTOR INFORMATION *(continued)*

ACCOUNT MAILING ADDRESS IF DIFFERENT FROM RESIDENTIAL/STREET ADDRESS

ADDRESS

CITY/STATE/ZIP

*The USA PATRIOT Act requires that all investors provide a street address for our records. If this information is not provided, there may be a delay in establishing the account.

☐ Yes ☐ No The Responsible Individual may change the beneficiary designated under this agreement to another member of the Designated Beneficiary's family described in Section 529(e)(2) in accordance with the Custodian's procedures.

☐ Yes ☐ No The Responsible Individual shall continue to serve as the Responsible Individual for the custodial account after the Designated Beneficiary attains the age of majority under state law until such time as all assets have been distributed from the custodial account and the custodial account terminates. If the Responsible Individual becomes incapacitated or dies after the Designated Beneficiary reaches the age of majority under state law, the Responsible Individual shall be the Designated Beneficiary.

If a box is not checked in response to the questions above, the answer will be deemed to be No.

SUCCESSOR RESPONSIBLE INDIVIDUAL

In the event of the death or legal incapacity of the Responsible Individual while the Designated Beneficiary is a minor under state law, the following shall become the Responsible Individual. If no successor is named, the Successor Responsible Individual shall be the Designated Beneficiary's parent or guardian.

SUCCESSOR RESPONSIBLE INDIVIDUAL'S FIRST NAME | MIDDLE INITIAL | LAST NAME

SUCCESSOR RESPONSIBLE INDIVIDUAL'S SOCIAL SECURITY NUMBER | DATE OF BIRTH | MOTHER'S MAIDEN NAME

RESIDENTIAL/STREET ADDRESS

RESIDENTIAL/STREET ADDRESS

CITY/STATE/ZIP

2 QUALIFICATION TO PURCHASE

I am a State Farm: ☐ Employee – Office Code: ☐ Agent State – State-Agent Code:

I am a retired State Farm: ☐ Employee ☐ Agent

I am a qualified family member of : ☐ Employee ☐ Agent

NAME OF STATE FARM EMPLOYEE OR AGENT

RELATIONSHIP TO EMPLOYEE OR AGENT | SOCIAL SECURITY NUMBER OF EMPLOYEE OR AGENT

3 SELECT YOUR FUND AND INITIAL INVESTMENT AMOUNT

The minimum investment for ESA's is $250 or $50 for each fund with Compensation and/or Automatic Investment Plan.

Please note that money orders, traveler's checks, and third-party checks are not accepted.

Fund Name	Fund Number	Amount
State Farm Growth Fund	871	$
State Farm Balanced Fund	872	$
State Farm Interim Fund	873	$

CHOOSE YOUR INVESTMENT METHOD

Investment will be made by:

☐ Check Payable to State Farm Funds

☐ Wire (please call 800-447-0740 for instructions)

☐ Direct Rollover from another institution (please include a completed Coverdell ESA Rollover Form)

CHOOSE YOUR CONTRIBUTION TYPE

☐ Contribution for Tax Year _____

Note: If no Tax Year is indicated, the default value will be the current year in which your contribution is received by the Custodian.

☐ Direct Rollover from another institution (please include a completed Coverdell ESA Rollover Form).

☐ Rollover from a previous ESA plan custodian in which you took receipt of assets

4 ESTABLISH AUTOMATIC INVESTMENT PLANS *(Optional)*

After the fund minimum of $250 has been met, an automatic investment plan can be established for as little as $50 each month from your bank account on file. In order to establish an automatic investment plan, please complete this section and provide your bank information and preprinted voided check in section 8. Note that automatic investments will be made as current year contributions.

FUND/ACCOUNT NUMBER	AMOUNT	FREQUENCY select one: ☐ monthly ☐ quarterly ☐ semiannually ☐ annually	START DATE (mm/dd/yyyy) (Please choose a start date no later than the 28th; if no date is selected, the 1st will be used.)

5 COMPENSATION DEDUCTION *(optional – TO BE COMPLETED BY AGENT/EMPLOYEE)*

All deduction authorizations remain in effect until the Fund is notified in writing or by phone to the contrary.

Minimum compensation deduction is **$50.00 per fund per frequency. An initial $50 contribution by check or EFT is required to establish a compensation deduction.**

☐ Employee ☐ Agent*

1st Check	2nd Check	Fund	Social Security Number	Signature(s)**
$	$			
$	$			
$	$			

*Agent deductions will be taken on the 15th and 30th of the month. **Signature(s) required for all compensation deductions.

6 DIVIDEND AND CAPITAL GAIN DISTRIBUTIONS

Dividend and Capital Gains distributions will be automatically reinvested.

In order to request distributions from your ESA account, the Coverdell ESA Distribution Form must be completed.

7 TELEPHONE/ONLINE PRIVILEGES

Privileges to exchange between identically registered accounts via telephone/online will automatically be established on your account unless you indicate otherwise below:

☐ I do not want telephone/online privilege

8 BANK INFORMATION

Complete this section if you would like to maintain bank instructions on file for payment of redemptions or distributions, or if you are establishing an automatic investment plan. **Please attach a preprinted voided check.**

NAME ON BANK ACCOUNT

BANK NAME

BANK ADDRESS

ACCOUNT NUMBER

ROUTING NUMBER

☐ Checking Account ☐ Savings Account

9 ADDITIONAL STATEMENTS

Complete this section if you would like duplicate statements of your account information to go to an interested party.

NAME

ADDRESS

CITY/STATE/ZIP

10 ELECTRONIC DELIVERY CONSENT

Accept the terms of the Electronic Delivery Consent Agreement below:

1. I agree to receive the following documents through electronic delivery rather than in paper format: all current and future shareholder and fund information including, but not limited to, statements, confirmations, tax forms, the funds' semi-annual and annual reports, prospectuses, proxy statements and newsletters. When the document(s) are available, State Farm will send a message to your Email address instructing how you may access your document(s).
2. This consent to receive documents electronically is effective until you withdraw it.
3. You can withdraw your consent to receive documents electronically at any time by calling or writing State Farm Mutual Funds.
4. You can obtain paper copies of electronic documents free of charge at any time by calling or writing State Farm Mutual Funds.
5. You may incur additional costs (for example, printing) and possible risks (for example, system outages) associated with electronic delivery.

By providing my email address below, I consent to this agreement.

E-MAIL ADDRESS

11 TRUSTED CONTACT INFORMATION (OPTIONAL)

In conjunction with FINRA Rule 2165 and FINRA Rule 4512, we are seeking to obtain the name and contact information for a "trusted contact" person for shareholder accounts. We could reach out to the "trusted contact" if, for example, we were unable to contact you after multiple attempts, or if you became subject to a disability, or we had reason to believe that you were being abused or exploited by a third party.

If you choose to provide information about a trusted contact person, you agree that the trusted contact you have listed below may be contacted by the firm about your account. You are also agreeing that the firm, or an associated person of the firm, is authorized to contact the trusted contact, and disclose information about your account, to address possible financial exploitation, to confirm the specifics of your current contact information, health status, or the identity of any legal guardian, executor, trustee or holder of a power of attorney, or as otherwise permitted by FINRA Rule 2165. You are not required to provide a trusted contact person to us.

Please note, assigning a trusted contact does not give the trusted contact any discretionary authority over your account; accordingly, the individual you list, on the basis of being listed as a trusted contact, will not be able to make purchases, effectuate sales or disbursements, or conduct any other activity.

TRUSTED CONTACT NAME

ADDRESS

CITY/STATE/ZIP/COUNTRY

RELATIONSHIP TO OWNER (OPTIONAL)

TELEPHONE

EMAIL ADDRESS

12 SIGN YOUR NAME

All account owners or trustees must sign below. Please sign exactly as your name appears in Section 1.

- I am of legal age and have received and read the current prospectus for the funds I am investing in.
- I understand that shares of the funds are not insured or guaranteed by the FDIC or any other governmental agency.
- Federal Law requires the Funds to obtain, verify and record identifying information, which may include the name, residential or business street address, taxpayer identification number, or other identifying information, for each investor who opens an account. Applications without the required information, or without an indication and supporting documentation showing that a taxpayer identification number has been applied for, may not be accepted. After acceptance, the Funds reserve the right to (1) place limits on transactions in any account until the identify of the investor is verified; or (2) refuse an investment in the Funds; or (3) redeem shares and close an account in the event that an investor's identify is not verified. The Asset Management Fund and its agents will not be responsible for any loss resulting from the investor's delay in providing all required information or from restricting transactions or closing an account when an investor's identity is not verified.
- Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number or I am waiting for a number to be used to me and (2) I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or (c) the IRS has notified me that I am no longer subject to backup withholding; and (3) I am a US person. Cross out item 2 if it does not apply to you. The IRS does not require your consent to any provision on this application other than the certification required to avoid backup withholding.

I adopt this Coverdell ESA, appointing The Northern Trust Company to act as Custodian, and to perform administrative services. I have received and read and understand the 5305-EA Plan Agreement and Disclosure Statement. I understand that the Custodian may charge fees to which reference is made in the Disclosure Statement and they may be separately billed or collected by redeeming sufficient shares from each portfolio account balance. I will supply the IRS with information as to any taxable year required unless filed by the Custodian.

I have read, and I accept the Custodial Agreement herin, by reference. I appoint The Northern Trust Company, or its successors, as Custodian of the accounts.

SIGNATURE OF DEPOSITOR	PRINTED NAME	DATE
SIGNATURE OF RESPONSIBLE INDIVIDUAL	PRINTED NAME	DATE