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P.O. Box 11237
South Bend, IN 46634-0237

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

POWER OF ATTORNEY
2000 063330 AND 2000 AUG 31 AM 9 06

HEALTH CARE REPRESENTATIVE APPOINTMENT
OF

RAYMOND O. MEINERT

Social Security No. 317-14-9066

STOP
This Document is the property of
the Lake County Recorder!

I hereby authorize and appoint an Attorney-in-Fact with power to exercise or perform any act, power, duty, right, or obligation whatsoever that I now have or may hereinafter acquire, relating to any person, matter, transaction, or property, real or personal, tangible or intangible, now owned or hereafter acquired by me, to be done on my behalf with the same force and effect as though I were present and acting for myself, including, without limitation and by way of example, the powers listed below.

In addition, I hereby authorize and appoint a Health Care Representative to act on my behalf pursuant to IC 16-36-1, as it exists now and is amended in the future with regard to questions of medical services, and to consent to, or withhold consent for medical treatment, emergencies or otherwise, if at any time I should be incapable of giving or withholding said consent on my own behalf.

My Attorney-in-Fact and my Health Care Representative may hereinafter be referred to as my "Representative" or "Representatives" as well as my "Attorney-in-Fact" or my "Health Care Representative." Any reference herein to Representative will be deemed a reference to whoever is acting as Representative or co-Representative whether original, alternate or successor.

It is to be understood that the authority and powers I have given to my Representative are in no way intended to limit or restrict my own authority or decision making capabilities as long as I remain mentally competent.

FILED

AUG 30 2000

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LAKE COUNTY AUDITOR

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I. GENERAL PROVISIONS

A. **REPRESENTATIVE.** As my Representative, I name:

JAMES R. MEINERT and NANCY NELSON.

If more than one Representative is named, MARK one of the following:

- My Representatives can act independently of one another
- My Representatives must act collectively and together
- My Representatives must act by majority vote

If both cannot act because of the death, disappearance, disability or resignation of one, then the other will continue to serve without the necessity of the appointment of a successor Representative. Death or disappearance may be established by affidavit, disability may be established by the certificate of a licensed physician, and resignation may be established by written resignation by the other Representative.

B. **SUCCESSOR REPRESENTATIVE.** If my original Representative fails or ceases to serve as my Representative, I name:

NONE

If more than one Representative is named, MARK one of the following:

- My Representatives can act independently of one another
- My Representatives must act collectively and together
- My Representatives must act by majority vote

In the event of the death, disappearance, disability or resignation of my first named Representative, the appointment of my successor Representative will become absolute, as if the first named Representative had not been appointed. The disappearance of my first named Representative may be established by the affidavit of my successor Representative. The disability

of my first named Representative may be established by the certificate of a licensed physician stating that the first named Representative is unable to manage his or her own affairs. Any person dealing with my successor Representative will be fully protected and free from liability for any payment, application, or accumulation made or other action taken in reliance upon such an affidavit of disappearance or such certificate of disability.

C. **LIMITED LIABILITY.** My Representative will only be liable for the acts or omissions undertaken in bad faith.

D. **FEE.** My Representative will be entitled to:

- A reasonable fee for services
- No fee

A reasonable fee not to exceed \$ _____

E. **PRIOR POWERS OF ATTORNEY AND HEALTH CARE REPRESENTATIVE APPOINTMENTS.** This Power of Attorney and Health Care Representative Appointment:

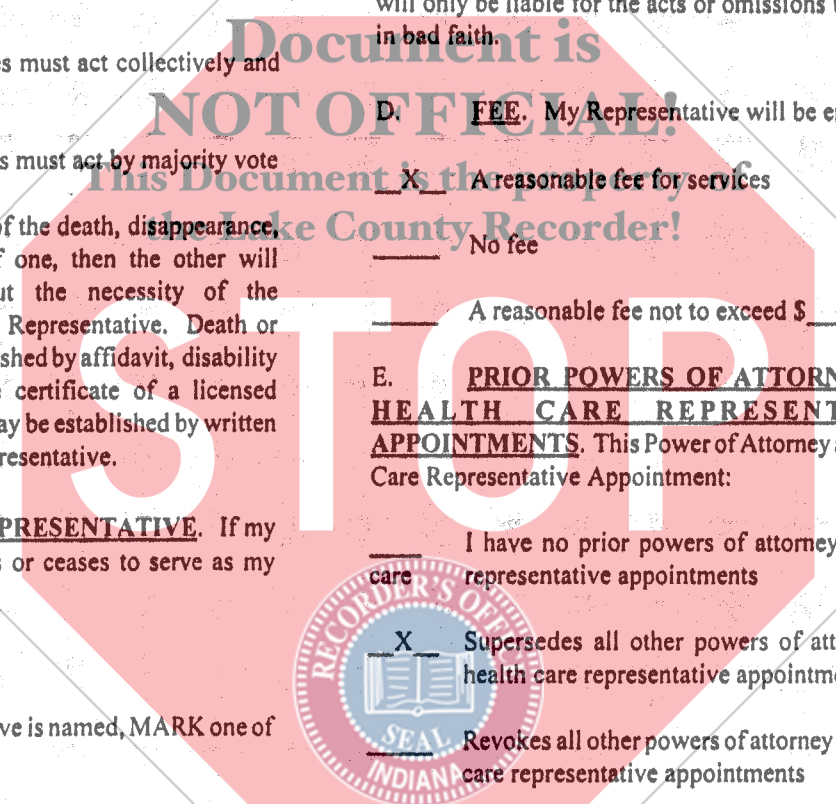
I have no prior powers of attorney or health care representative appointments

Supersedes all other powers of attorney and health care representative appointments

Revokes all other powers of attorney and health care representative appointments

Revokes all other powers of attorney and health care representative appointments except as to a specific property interest owned by me and identified in the power of attorney or a specific medical condition identified in a health care representative appointment signed by me prior to the date of this Power of Attorney and Health Care Representative Appointment. This Power of Attorney and Health Care Representative Appointment supersedes all powers of attorney and/or health care representative appointments not revoked.

F. **TERMINATION.** Without regard to my mental or physical condition, this Power of Attorney and



Health Care Representative Appointment will continue in effect until:

X My death or until revoked, whichever comes first.

_____ or until my death, whichever comes first.

G. **RATIFICATION.** I hereby ratify and confirm all that my Representative may do by virtue of this Power of Attorney and Health Care Representative Appointment.

H. **PHOTOCOPY.** A person may rely on the receipt of a copy, photostatic copy, facsimile reproduction or other similar reproduction of this signed Power of Attorney and Health Care Representative Appointment as if that person had received the originally signed document.

I. **NO LIABILITY TO THIRD PARTIES.** It is understood that my Representative does not become personally liable for his or her actions hereunder for which my Representative would not otherwise be liable, simply by virtue of acting under this Power of Attorney and Health Care Representative Appointment. I agree to be financially responsible for any goods or services (including health care services) performed in reliance upon documents signed or oral contracts agreed to by my Representative for which I would have been financially responsible had I made the decision.

J. **INDUCEMENT FOR RELIANCE BY THIRD PARTIES.** To induce third parties to act in accordance with the powers granted to my Representative, I represent and warrant that:

(1) If this Power of Attorney and Health Care Representative is revoked or amended for any reason, I, my estate, my heirs, successors, and assigns will hold any third party harmless from any loss suffered, or liability incurred, by the third party in acting in accordance with this Power of Attorney and Health Care Representative Appointment before the third party's receipt of written notice of termination or amendment; (2) The powers conferred on my Representative may be exercised alone; my Representative's signature or actions under the authority granted in this Power may be accepted by third parties as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf; (3) No person who acts in reliance upon any representation of my Representative as

to the scope of my Representative's authority granted under this Power of Attorney and Health Care Representative Appointment will incur any liability to me, my estate, my heirs, successors, or assigns for permitting my Representative to exercise any such power, nor will any person who deals with my Representative be responsible for determining or ensuring the proper application of funds or property.

K. **RIGHT TO SEEK COURT ORDERS OR FILE SUIT.** My Representative will have the right to seek appropriate court orders mandating acts which he or she deems appropriate if a third party refuses to comply with actions which are authorized by this Power of Attorney and Health Care Representative Appointment or for the purpose of enjoining acts by third parties which my Representative has not authorized. In addition, my Representative may sue a third party who fails to comply with actions I have authorized my Representative to take and demand damages, including punitive damages, on my behalf for such noncompliance. IC 30-5-9-9 states:

[A] PERSON REFUSING TO ACCEPT THE AUTHORITY OF AN ATTORNEY IN FACT TO EXERCISE A POWER GRANTED UNDER A POWER OF ATTORNEY IS LIABLE TO THE PRINCIPAL AND TO THE PRINCIPAL'S HEIRS, ASSIGNS, AND THE PERSONAL REPRESENTATIVE OF THE ESTATE OF THE PRINCIPAL IN THE SAME MANNER AS THE PERSON WOULD BE LIABLE HAD THE PERSON REFUSED TO ACCEPT THE AUTHORITY OF THE PRINCIPAL TO ACT ON THE PRINCIPAL'S OWN BEHALF.

L. **GUARDIAN.** If protective proceedings are instituted on my behalf or a guardian is requested to act on my behalf, I name my Representative to act on my behalf or as my guardian.

M. **GUARDIAN OF SPOUSE OR CHILD.** If protective or guardianship proceedings are begun on behalf of a Spouse or Child of mine, if any, I name my Representative to act on behalf of such Spouse or Child or as such Spouse's or Child's guardian.

N. **VALID IN OTHER JURISDICTIONS.** This Power of Attorney and Health Care Representative Appointment is intended to be valid in any jurisdiction in which it is presented.

O. **ACT IN MY BEST INTERESTS.** By

accepting this appointment my Representative affirms and agrees to act solely in my best interests without regard to any other interested third party.

P. **WAIVER OF PHYSICIAN-PATIENT PRIVILEGE.** I hereby waive voluntarily any physician-patient privilege or psychiatrist-patient privilege that may exist in my favor and I authorize physicians to examine me and disclose my mental or physical condition in order to determine my incapacity or capacity for purposes of this Power of Attorney and Health Care Representative Appointment. The licensed physicians and/or psychiatrists who act under this paragraph will not be liable to me for any actions taken by them in good faith under this paragraph.

II. POWER OF ATTORNEY PROVISIONS

A. **EFFECTIVE DATE.** This Power of Attorney and Health Care Representative Appointment will be effective:

_____ At 12:01 a.m. on _____

X Immediately

_____ Upon and during my disappearance or incapacity, or upon my signing a certificate that from and after the date of execution thereof my Attorney-in-Fact is fully authorized to act under this Power of Attorney and Health Care Representative Appointment.

B. **ESTABLISHMENT OF DISAPPEARANCE OR INCAPACITY.** My disappearance may be established after a period of 30 days by the affidavit of my Attorney-in-Fact. My incapacity, for this purpose, may be established by the written statement of a licensed physician (if possible, my own physician) stating that I am unable to substantially manage my affairs. A copy of the Attorney-in-Fact's affidavit or the physician's statement will be attached to the original of this Power of Attorney and Health Care Representative Appointment (and photocopies thereof will be attached to photocopies of this Power of Attorney and Health Care Representative Appointment) and if this Power of Attorney and Health Care Representative Appointment is filed or recorded among public records, then such affidavit or statement will also be similarly filed or recorded if permitted by

applicable law. My Attorney-in-Fact will be fully protected and free from any liability for any payment, application or accumulation made or other action taken in reliance upon such an affidavit or statement.

C. **REAPPEARANCE OR REGAINING CAPACITY.** I will be deemed under this Power of Attorney and Health Care Representative Appointment to have regained capacity upon presentation to my Attorney-in-Fact of a statement signed by a licensed physician (if possible, my own physician) which states the opinion of such physician that I am capable of caring for myself or that I am physically and mentally capable of managing my affairs. I will be deemed under this Power of Attorney and Health Care Representative Appointment to have reappeared upon the presentation to my Attorney-in-Fact of a statement signed by me so indicating. Either such statement shall be attached to the original of this Power of Attorney and Health Care Representative Appointment (and photocopies thereof shall be attached to photocopies of this Power of Attorney and Health Care Representative Appointment) and if this Power of Attorney and Health Care Representative Appointment is filed or recorded among public records, then such statement will also be similarly filed or recorded if permitted by applicable law.

If this Power of Attorney and Health Care Representative Appointment became effective because of my incapacity or disappearance and subsequently I am no longer incapacitated or having reappeared, this Power of Attorney and Health Care Representative Appointment will not be revoked but will become effective again upon my subsequent disappearance or incapacity as provided above or upon my subsequent certification that such power will be or has become effective.

D. **STATUTORY POWERS.** I give to my Attorney-in-Fact or any successor Attorney-in-Fact the powers specified in this section, incorporating by reference the Indiana Code Sections 30-5-5-2 to 30-5-5-19, to be used on my behalf, and the authority with respect to:

REAL PROPERTY transactions; **TANGIBLE PERSONAL PROPERTY** transactions; **BOND, SHARE AND COMMODITY** transactions; **BANKING** transactions, including the power to drill a safe deposit box in-the event the keys are lost or misplaced; **BUSINESS** operating transactions; **INSURANCE** transactions, without any limitation on the Attorney-in-Fact being named as beneficiary of any contracts of insurance; **BENEFICIARY** transactions; **GIFT** transactions,

without any limitations on the ability to make or the amount of gifts to the Attorney-in-Fact or a person that the Attorney-in-Fact has a legal obligation of support; **FIDUCIARY** transactions; **CLAIMS AND LITIGATION**; **FAMILY MAINTENANCE**; **MILITARY SERVICE** benefits; **RECORDS, REPORTS AND STATEMENTS**, including the power to sign on my behalf any specific power of attorney required by any taxing authority to allow my Attorney-in-Fact to act on my behalf before that taxing authority on any return or issue; **ESTATE TRANSACTIONS**; **HEALTH CARE**, and I appoint my Attorney-in-Fact as my Health Care Representative with authority to act for me in all matters of health care in accordance with IC 16-36-1; **DELEGATING** authority; and **ALL OTHER MATTERS**.

E. ADDITIONAL POWERS. In addition to the powers set forth in IC 30-5-5-1 *et seq.*, I give to my Attorney-in-Fact or any successor Attorney-in-Fact the powers specified in this section to be used on my behalf:

1. **Tax Powers.** To prepare, sign, and file joint or separate income tax returns or declarations of estimated tax and to act without limitation upon my behalf with regard to federal income taxes (Forms 1040, 1040EZ, 1040A, etc.), state and local income taxes, gift (Form 709), estate (Form 706), and other tax returns of all sorts, including where appropriate joint returns, FICA returns, payroll tax returns, claims for refunds, requests for extensions of time to file returns or pay taxes, extensions and waivers of applicable periods of limitation, protests and petitions to administrative agencies or courts, including the tax court, regarding tax matters, and any and all other tax-related documents, including but not limited to consents and agreements under Section 2032A of the Internal Revenue Code or any successor section thereto and consents to split gifts and closing agreements, for all tax periods from 1980 through 2020, and for all jurisdictions; to complete Internal Revenue Service Form 2848, Power of Attorney and Declaration of Representative (or other prescribed form) on my behalf as well as to perform all other functions contemplated by that form whether they are required or merely permissible; to consent to any gift and to utilize any gift splitting provisions or other tax election; to prepare, sign, and file any claims for the refund of any tax; to post bonds, receive confidential information and contest deficiencies determined by the Internal Revenue Service or any state or local taxing authority; to exercise any and all elections that I may have under federal, state, or local tax laws including

without limitation the allocation of any generation skipping tax exemption to which I may be entitled; and to the extent that I may have omitted some power or discretion, some tax period, some form or some jurisdiction, I hereby grant to my Attorney-in-Fact the power to amend the Internal Revenue Service form power of attorney (presently Form 2848 or Form 2848-D) in my name.

2. **Power to Make Gifts.** To make gifts, grants, or other transfers (including the forgiveness of indebtedness and the completion of any charitable pledges I may have made) without consideration either outright or in trust to such a person or organizations as my Attorney-in-Fact will select, including gifts to my Attorney-in-Fact. If I am in a long-term care facility, or if my Attorney-in-Fact believes in good faith that my entry to such a facility is both necessary and imminent, my Attorney-in-Fact will have the power to make gifts or the power to direct the Trustee of a revocable trust of which I am settlor to transfer all or a portion of my trust assets to any person including my Attorney-in-Fact if (i) they would not interfere with entry to the nursing home which is most appropriate and comfortable for me, and (ii) they are necessary to preserve a portion of my estate for my heirs, beneficiaries or beneficiaries named in my revocable trust.

3. **Estate Planning Powers.** To create an estate plan for the benefit of my spouse, children, or other issue, including, but not limited to, the creation of revocable or irrevocable trusts, even though my Attorney-in-Fact is a member of the group that may benefit under the estate plan; to take such action or to apply such funds in such fashion as my Attorney-in-Fact determines is in keeping with my wishes and interests so far as they can be ascertained, without a petition to or leave of court, for the purpose of conserving my property, benefiting my descendants and other relatives, minimizing current or prospective federal and state taxes, and maximizing entitlement to federal and state medical, welfare, housing, and other public programs (including, but not limited to, Social Security, Supplemental Security Income, Medicare, Medicaid, and In Home Support Services), by all legitimate and proper means within the sound and trusted discretion of my Attorney-in-Fact, including, without limitation, gifts to such relatives, friends, and charities as would likely be the recipients of donations from me, and revocable or irrevocable transfers into trusts for the benefit of myself and/or other said recipients; to consult with lawyers, accountants, or other advisors in carrying out the powers granted herein, to rely on the advice given by such

advisors, and to pay all expenses incurred in carrying out the powers hereunder out of my assets; to designate such Trustee or Trustees as my Attorney-in-Fact deems advisable, including but not limited to my Attorney-in-Fact, or any children of mine, or any other issue; to transfer any and all of my property, of whatever kind, to any trust created pursuant to this Power of Attorney and Health Care Representative Appointment or to any person who is a permitted donee of a gift, and to sign deeds, stock powers, withdrawal slips, or any other document or instrument my Attorney-in-Fact may deem advisable in carrying out any of my Attorney-in-Fact's powers hereunder. As a guide to my Attorney-in-Fact in creating an estate plan, my primary aim is to preserve my assets for the benefit of my spouse during my spouse's lifetime (if I have a spouse and if my spouse survives me) and for my children and their issue after my spouse's death (if I have children or issue and any such children or issue survives me). To the extent legally possible, it is my hope that my estate plan will protect my assets from being dissipated to pay for the cost of health, medical, or nursing home expenses and minimize the amount of estate taxes payable on my death. The decision of my Attorney-in-Fact as to the form and contents of my estate plan will be final and binding on all parties. I will be deemed for all purposes as the transferor of any trust created pursuant to this Power of Attorney and Health Care Representative Appointment.

4. **Power to Create and Transfer Assets to and from Trust.** To create any trust, revocable or irrevocable, for my benefit and that of my spouse and issue that I may have the power to create; to amend or revoke such trust or trusts or any other trust that I may have the power to amend or revoke; to transfer any and all of my tangible or intangible personal property or real property to any such trusts; to exercise such powers as my Attorney-in-Fact deems appropriate in his or her sole discretion. My Attorney-in-Fact has the power to withdraw and/or receive income or principal from any trust from which I have a right of withdrawal or receipt; to request and receive the income or principal of any trust from which the trustee has discretionary authority to make distributions to or on my behalf, and to sign any receipt, release, or other document that may be required of me by such trustee. In the event that I ever become a permanent resident of a long-term care facility (nursing home), I specifically give my Attorney-in-Fact the right to make any changes and/or amendments in any revocable trust of which I am a Settlor to do Medicaid Planning.

5. **Power With Respect to Employment Benefits:**

Power to Change Beneficiaries. My Attorney-in-Fact may change the names of beneficiaries of any retirement/employment benefit plans if a previously named beneficiary is deceased. My Attorney-in-Fact will only make changes that are consistent with my bequest plan as set forth in any will or revocable trust signed by me and then in effect. My Attorney-in-Fact may name himself or herself as such new or alternative beneficiary.

6. **Power to Obtain and Maintain Eligibility for Public Benefits.** My Attorney-in-Fact will have the power to take any and all steps necessary, in my Attorney-in-Fact's judgment, to obtain and maintain my eligibility for any and all public benefits and entitlement programs, including but not limited to, the power to express my intent to return to any home owned by me at the time from any long term care facility or nursing home. Such programs include, but are not limited to, Social Security, Supplemental Security Income, Medicare, Medicaid, and In Home Support Services.

III. HEALTH CARE REPRESENTATIVE PROVISIONS

A. **EFFECTIVE ON INCAPACITY.** This appointment of authority will not become effective until such time as I become incapable of consenting to, or withholding consent for, medical treatment as determined by my regular licensed physician, and will last only so long as the incapacity continues. In the event that my physician is unavailable or if consultation would be unadvisable due to the existence of some emergency, then the attending licensed physician will determine the extent to which I am capable of making decisions with regard to my medical treatment.

B. **EXAMPLES OF POWERS.** With regard to my health care, I specifically give my Health Care Representative broad powers, including, but not limited to the powers to:

1. Gain access to medical and other personal information;
2. Employ and discharge persons providing services;
3. Consent or refuse consent to medical care;
4. Refuse consent to life sustaining treatment in furtherance of my wish for limited treatment;
5. Provide for my spiritual or religious needs;

- 6. Provide for my companionship;
- 7. Provide for my recreational and sports activities and travel;
- 8. Arrange my funeral and make anatomical gifts;
- 9. Sign documents, enter into contracts, and pay reasonable compensation or costs in implementing the above powers.

C. **STOP HEALTH CARE.** I authorize my Health Care Representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my Health Care Representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my Health Care Representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or so instituted, even if death may result.

D. **CONSULTATIONS.** My Health Care Representative must try to discuss any proposed health care decisions with me. However, if I am unable to communicate, my Health Care Representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my Health Care Representative may also discuss this decision with my family and others, to the extent they are available. In making this decision, I request that my Health Care Representative and family consider the following:

- 1. My diagnosis and prognosis;
- 2. The risks, benefits and burdens to me of treatment;
- 3. The emotional burdens on me and my family;
- 4. The financial burdens on me and my family;
- 5. My statements of preference regarding health care as expressed in this Power of Attorney and Health Care Representative Appointment or my living will; it being my intention that these documents in no way limit the discretion of my

Representative, but instead, serve only as a guide for making these decisions;

- 6. Other statements regarding health care I have made, giving most weight to my most recent statements;
- 7. My ethical and religious principles.

E. **DELEGATION.** I further authorize my Health Care Representative to appoint a third party, in a signed and witnessed writing, to consent to, or withhold consent for, medical treatment on my behalf if my Health Care Representative cannot or will not be available to exercise that authority during a period when I am incapable of consenting or withholding consent on my own behalf. Such delegation of authority will not exceed the authority herein granted but may include such conditions as my Health Care Representative deems to be in my best interests. The third party so authorized to act on my behalf must satisfy all requirements of IC §16-36-1-6 for said grant of authority to be valid and effective.

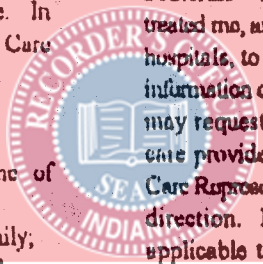
F. **AUTHORIZATIONS TO THIRD PARTIES.**

All third parties from whom my Health Care Representative requests information regarding my health are hereby authorized to provide such information to him or her without limitation and are released from any legal liability whatsoever to me, my estate, my heirs, successors or assigns for complying with his or her requests. I also authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Health Care Representative all information or photocopies of any records which he or she may request. All physicians, hospitals, and other health care providers are hereby authorized to treat my Health Care Representative's request or direction as my request or direction. I hereby waive all privileges which may be applicable to such information and records, and to any communication pertaining to me and made in the course of a physician-patient or psychiatrist-patient relationship.

I have signed this Power of Attorney and Health Care Representative Appointment on the 27 day of August, 1999.

Raymond O. Meinert

 RAYMOND O. MEINERT

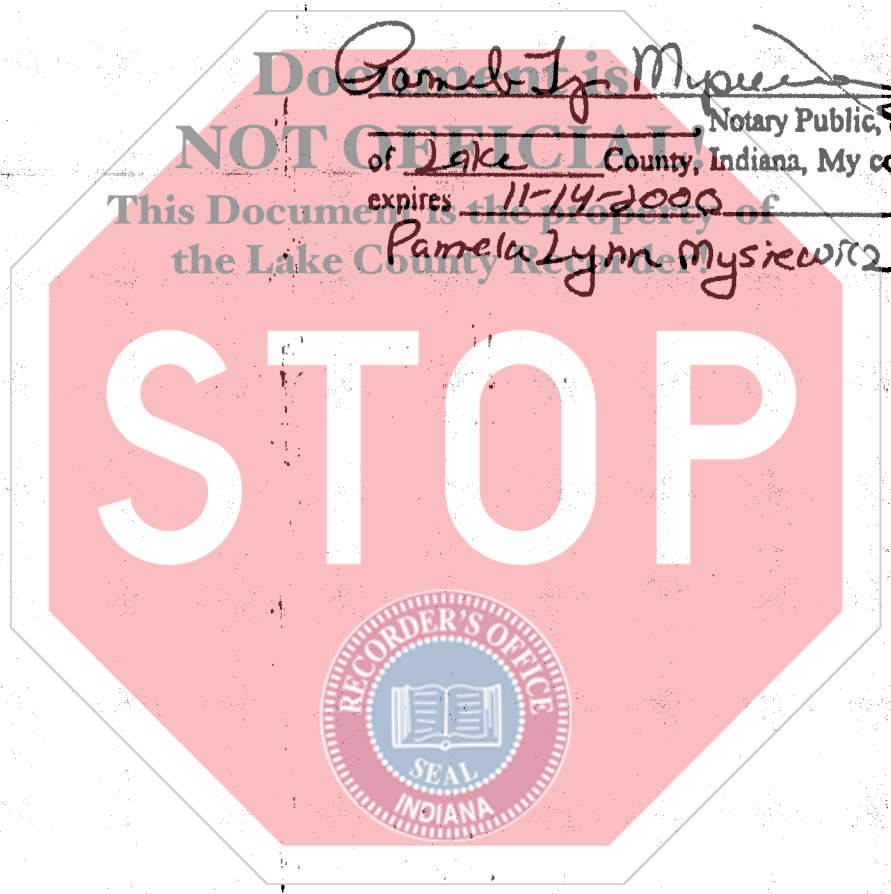


STATE OF INDIANA

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) SS:
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COUNTY OF ST. JOSEPH

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared the above-signed person and signed this Power of Attorney and Health Care Representative Appointment and acknowledged the signing of this Power of Attorney and Health Care Representative Appointment this 27 day of August, 1999.



This instrument was prepared by Michael C. Murphy, KONOPA & MURPHY, P.C., 221 West Wayne Street, Suite 200, Post Office Box 11237, South Bend, Indiana 46634-0237. Telephonc: (219) 239-1000