

DURABLE POWER-OF-ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That:

The undersigned, ALBINA A. WELLS, residing in Whiting, Lake County, Indiana, do hereby nominate and appoint my daughter, ANNE MARIE WELLS as my Attorney-in-Fact, for me and in my name and stead, to do each and all of the following acts and things:

(a) For me and in my name to sign my name to all of my Social Security Checks, Dividend Checks, Interest checks, Pension Checks, and any other checks payable to me.

(b) To deposit in or withdraw from any bank, trust company, savings association, safe deposit company, broker or other depository or agent, any monies or other property and to examine or receive related records, including cancelled checks.

(c) To pay my ordinary household expenses, to pay my medical, nursing, hospital, convalescent and other health care and treatment expenses, including permission for admission to hospitals and consent to treatment, and to make applications for insurance benefits related to such health care and treatment.

(d) To make and execute any and all Contracts; to purchase or to sell any or all of my stocks, bonds and securities; to take possession and delivery of all of my mail; to receive and to demand all sums of money which are now or shall hereafter become due or payable to me; to bargain for, contract concerning, buy, sell, mortgage and in any and every way and manner deal with personal property of any kind or nature; to execute instruments to effect the transfer of title to any motor vehicle owned by me; and to enter or open my safety deposit box, and including the power to sell all of my interest in any real estate that I may own, and to execute a Warranty Deed and all closing documents on real estate specifically including my home at 1532 Warwick Avenue, Whiting, Indiana.

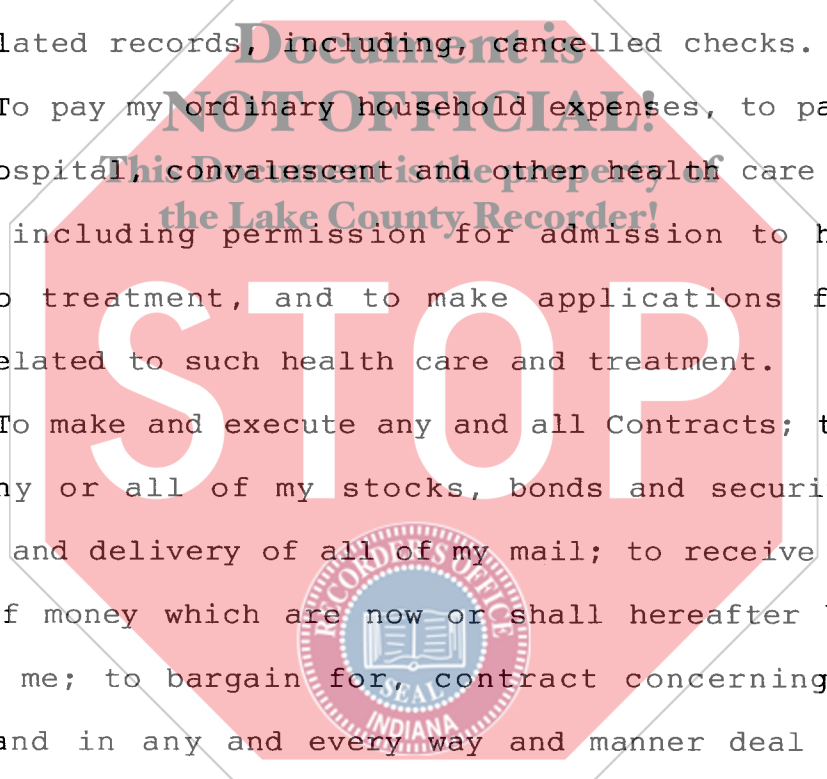
(e) For me in my name to deposit any and all sums collected and received in my name into any bank, in her name, and to withdraw same as she shall think fit in the payment of any debts payable by me or any taxes, assessments and any other expenses due

TICOR TITLE INSURANCE  
2050-45TH AVE  
HIGHLAND, IN 46322

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PETER BENJAMIN  
LAKE COUNTY AUDITOR

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Handwritten signature and initials.

and payable or to become due and payable, for the benefit of my support.

(f) To sign my name to all documents necessary to obtain any medical or hospitalization information and records, or to release such information to any lawful agent or authority for any purpose that my said Attorney may deem necessary, including permission to perform medical procedures for my benefit.

(g) To execute and file all of my individual tax returns, both state and federal, and to file amended income tax returns on my behalf and to pay all of my taxes, including any interest or penalties due thereon.

I hereby give and grant unto my said Attorney, full power and authority to do and perform all and every act and thing whatsoever which may be necessary, convenient, or proper to be done to effectuate the powers herein granted as fully as I could do if personally present, hereby ratifying and confirming all that my said Attorney shall lawfully do, or cause to be done, by virtue hereof.

Each person, partnership, corporation or other legal entity relying or acting upon this Power-Of-Attorney, shall be entitled to presume conclusively that this Power-Of-Attorney is in full force and effect, unless written notice shall have been given by me to such person, partnership, corporation or other legal entity that this power has been revoked.

THIS POWER-OF-ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCAPACITY, NOR BY LAPSE OF TIME, and the authority conferred herein shall be exercisable by my Attorney-In-Fact notwithstanding my future incompetence. All acts done by my Attorney-In-Fact pursuant to this Power-of-Attorney shall bind me, my heirs and personal representatives, it being my intention that this instrument shall constitute a durable power of attorney under the Indiana Uniform Durable Power of Attorney Law.

Furthermore, I appoint my daughter, ANNE MARIE WELLS, as my health care representative and I authorize her 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 not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such 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.

The powers herein granted may be terminated upon written notice delivered by me to my said attorney, whereupon said attorney shall forthwith deliver over to me all property of every kind and character taken into her possession pursuant to the powers herein granted.

