DURABLE GENERAL POWER OF ATTORNEY
BY NAOMI RUTH DODSON

I, **Naomi Ruth Dodson**, being at least 18 years of age and mentally competent, do hereby designate and appoint my sister, Gwendolyn Adell, a person who is over the age of twenty-one (21) as my true and lawful attorney-in-fact.

2014 082168

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2014 DEC 24 PM 2:38
MICHAEL B. BROWN
RECORDER

POWERS

I give to my attorney-in-fact the powers herein specified to be used on my behalf. I am incorporating by reference herein those powers which comply with my wishes in accordance with the manner prescribed by Ind. Code 30-5-5. The powers given herein shall be considered limited so that my attorney-in-fact shall not have any power which would cause my attorney-in-fact to be treated as the owner of any interest in my property and which would cause that property to be taxed as owned by the attorney-in-fact, it being my intention not to grant any beneficial interests in my estate by this instrument. By way of illustration only, and not intending any limitation, I specifically grant to my attorney-in-fact the following POWERS:

A. BANKING: With respect to banking transactions, including but not limited to, the authority to have access to any and all safety deposit boxes in my name, and to open, inspect, inventory, place items in or remove items from and close any safety deposit boxes. Deposit/withdraw in either my name, the attorney's name, or jointly in both names, funds, negotiable paper, credit, rights, or money that may come into the attorney's hands or that may be on deposit for me.

B. PROPERTY (REAL OR PERSONAL): Buy, receive, lease, accept, or otherwise acquire any property. (As used in this Power, the word "property" shall include any custody, possession, interest, or right pertaining to property of any character, wheresoever situated.) Sell, convey, mortgage, hypothecate, pledge, quitclaim, or otherwise dispose of or encumber any property. Contract or agree for the acquisition, disposition, or encumbrance of any property.

Take, hold, possess, invest, lease, let, or otherwise manage my property. Eject, remove, or relieve tenants, holders, or others of possession of my property. Maintain, protect, preserve, insure, remove, ship, store, transfer, repair, rebuild, modify, subdivide, or improve my property. Enter safety deposit boxes and remove or deposit items.

C. BUSINESS: Transact any kind of business, including the receipt, recovery, collection, payment, compromise, settlement, or adjustment of accounts, legacies, bequests, distributions, interests, employee benefits, annuities, distributions, demands, debts, taxes, and obligations due or payable by or to me.

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D. CLAIMS AND LITIGATIONS: Institute, prosecute, litigate, defend, compromise, arbitrate, or dispose of legal, equitable, or administrative claims, defenses, hearings, actions, suits, attachments, arrests, distresses, or other proceedings.

E. BONDS, SHARES and COMMODITIES: Act as attorney or proxy with respect to any securities, shares, stocks, bonds, or other investments, rights, or interests.

F. INSURANCE: With respect to insurance transactions, shall have the right to change, directly or indirectly, the beneficiary of any policy insuring my life to any natural person. This authority shall include full power to apply for and otherwise deal with Medicare and Medicaid benefits and any other benefits provided by Social Security or any other governmental plan or policy.

G. RECORDS, REPORTS, AND STATEMENTS: With respect to records, reports, and statements, including but not limited to, the power to execute 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.

H. GIFTS: In the event it becomes necessary for my Attorney-in-Fact to take immediate action to eliminate items which are burdensome, then I direct that all such gifts be made in accordance with the provisions set out according to Indiana Law.

I. ALL OTHER MATTERS: With respect to all other matters pursuant to Ind. Code 30-5-5 and affairs affecting property owned by me the same shall be regulated pursuant to Indiana Law, but not authority to make medical decisions on my behalf which authority has been granted in a separate power of attorney executed this same date.

EFFECTIVE DATE

This Power of Attorney shall be effective as of the date it is signed. My disability or incompetence shall not affect or terminate this Power of Attorney. This Power of Attorney shall terminate upon the execution and recordation with the Recorder's Office of the county of my domicile of a written revocation hereof.

DURABLE EFFECT

THIS POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCAPACITY OR BY LAPSE OF TIME.

GUARDIAN

If proceedings are ever begun for the appointment of a guardian, conservator, or like representative for my person or estate, it is my preference that whoever may be serving as my attorney-in-fact under this power be appointed to that office.

TRUSTS

My attorney-in-fact is expressly authorized to create, revoke, or amend trusts in my name and to transfer any of my property to the trustee for administration and disposition in accordance with the provisions of such a trust or the provisions of any trust that I may establish.

AUTHORITY TO DELEGATE

My attorney-in-fact shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my attorney-in-facts may select.

MINISTERIAL NATURE OF POWERS

It is not my intention to grant any beneficial interests in my estate by this instrument but to grant management, investment, and custody of my estate. The powers granted are to be exercised in a fiduciary capacity for my benefit and (except for the provision of reasonable compensation for services) not for the personal benefit of my attorney-in-fact.

FEES

My attorney-in-fact shall be entitled to a fee for services provided as my attorney-in-fact.

LIABILITY AND INDEMNITY

My attorney-in-fact shall only be liable for actions undertaken in bad faith; provided, however, my attorney-in-fact shall be liable for the negligent exercise of the powers described herein if the exercise of such power involves self dealing. I hereby ratify and confirm all that my attorney-in-fact shall do by virtue hereof. Further, I agree to indemnify and hold harmless anyone who in good faith, acts under this Power of Attorney or transacts business with my attorney-in-fact in reliance upon this Power, without actual knowledge of its revocation.

SUCCESSOR ATTORNEY-IN-FACT

I hereby appoint my sister, **PAULA JOHNSON ROBERTS** as my successor attorney-in-fact.

CONDITIONS PRECEDENT TO AUTHORITY OF SUCCESSOR ATTORNEY-IN-FACT

In the event of the death, disappearance, disability, or resignation of any of my first

named attorney-in-fact, the appointment of my successor attorney-in-fact shall become absolute, the same as if the first named attorney-in-fact had not been appointed. The disappearance of my first named attorney-in-fact may be established by the affidavit of my alternate attorney-in-fact. The disability of my first named attorney-in-fact may be established by the certificate of a qualified physician stating that the first named attorney-in-fact is unable to manage her own affairs. Any person dealing with my alternate attorney-in-fact shall be fully protected and free from liability for any payment, application, or accumulation made or other action taken in reliance upon such an affidavit or disappearance or such a certificate of disability. The authority of my alternate attorney-in-fact shall continue and be exclusive even if the first named attorney-in-fact shall reappear after a disappearance or recover after a disability.

APPLICABLE LAW

This power of attorney is executed and delivered in Indiana in contemplation of Indiana law, and it shall be interpreted and governed in accordance with Indiana law.

I AM FULLY INFORMED AS TO ALL THE CONTENTS OF THIS DOCUMENT AND UNDERSTAND THE FULL IMPORT OF THIS GRANT OF POWERS TO MY ATTORNEY-IN-FACT.

REVOCATION

I HEREBY REVOKE ALL PRIOR GRANTS OF POWER OF ATTORNEY. I reserve the right to revoke this power of attorney at any time.

IN WITNESS WHEREOF, the said **NAOMI RUTH DODSON** has hereunto set her hand and seal this 24 day of December 2013, at Gary, Indiana.

Naomi Ruth Dodson (Signature)

NAOMI RUTH DODSON (Printed Name)

STATE OF IN, COUNTY OF Lake, ss:

Before me a Notary Public in and for said county and state residing in, Lake County, personally appeared the Grantor, Naomi Ruth Dodson, known to me, or evidenced to me to be, and who acknowledged the execution of the foregoing Power of Attorney.

Naomi Ruth Dodson

WITNESS my hand and Notarial Seal this 24th day of ~~June~~ Dec, 2014.

Yolanda Bond [Signature]

NOTARY PUBLIC YOLANDA Bond [Printed Name]

My Comm. Exp.: 6/6/2017

RESIDENT COUNTY: Lake

SEAL

Yolanda T. Bond
Resident Of
Lake County
My Commission Expires:
6/6/2017

Prepared By: Attorney Cynthia I. Taylor , 7863 Broadway, Suite 217, Merrillville, Indiana 46410 (219) 951-4290 (877) 384-0087 fax

HEALTH CARE DECLARATION

AND

DURABLE HEALTH CARE POWER OF ATTORNEY

OF

NAOMI RUTH DODSON

I, Naomi Ruth Dodson, having been born on July 16, 1973, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make the following declarations, designate the persons hereafter named to make health care decisions on my behalf in the event of my incapacity and I make known my desires that my life or dying shall not be artificially prolonged under the circumstances set forth below. I therefore declare:

I. DECLARATION UNDER INDIANA'S LIVING WILL LAW

If at any time I have an incurable injury, disease, or illness certified in writing to be a terminal condition by my attending health care provider(s) [hereinafter "physician(s)"], and my attending physician(s) has determined that my death will occur within a short period of time, and the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the providing of appropriate nutrition, hydration, the administration of medication and the performance of any medical procedure necessary to provide me with comfort and care or to alleviate pain.

Without limiting the generality of the foregoing I specifically state the following regarding certain procedures and circumstances:

_____ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my Health Care Representative appointed under IC

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16-36-1-7 or my attorney-in-fact with health care powers under IC 30-5-5.

B. Antibiotics. If I develop an infection and the provision of treatment such as antibiotics might forestall my death but not increase my level of comfort, then I direct such treatments be withheld or withdrawn.

C. Resuscitation. I do not want electrical or mechanical resuscitation of my heart when it has stopped beating if there is not a reasonable chance that I will recover to a meaningful, sentient life and in such circumstances I authorize and direct my treating physician(s) to enter a "Do Not Resuscitate" order in my medical record.

D. Pain Medication. I authorize the use of pain medication or other treatments to provide me with comfort even if such treatments may hasten my death.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this Declaration be followed by my Health Care Representative and honored by my family, physician and any health care facilities in which I am a patient as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of my refusal as I have. I understand the full impact of this declaration.

II. DECLARATION IN RELATION TO HEALTH CARE IF I AM IN A COMA OR A PERSISTENT VEGETATIVE STATE

I intend to take full advantage of Indiana's Living Will Law. However, I do not intend my right to refuse treatment to be limited to the terminal circumstances described in the Living Will Statute but also wish to exercise my Constitutional and Common Law right to refuse consent to health care if I am in a coma or a persistent vegetative state which is reasonably concluded to be irreversible. Therefore, I authorize and direct my attending physician(s) to withhold or withdraw treatment as described in the foregoing section of this document even if I am not considered to be in a terminal condition but am in a coma or persistent vegetative state which is reasonably determined to be irreversible.

I further authorize my Health Care Representative to direct the withholding or withdrawal of treatments in such circumstances.

III. APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I hereby appoint my sister, **Gwendolyn Adell,** as my attorney-in-fact for health care decisions ("Health Care Representative") who is authorized to act for me in all matters of health care in accordance with I.C. § 16-8-12 and I.C. § 30-5. Should Gwendolyn Adell be unable or unwilling to serve as my attorney-in-fact for health care decisions, I then appoint my sister, Paula Johnson Roberts as my successor Health Care Representative.

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A. When this Designation of Health Care Representativeand Power of Attorney Shall be Effective:

This Designation of Health Care Representative and Power of Attorney is effective when I become incapable of consenting to my own health care, as may be determined by my treating physician(s), and the authority granted herein is effective only so long as I remain incapable of consenting to my own health care.

B. Prior Designations Revoked.

I revoke all Durable Health Care Powers of Attorney and Appointments of Health Care Representative previously executed by me. Further, I revoke all provisions of any other Powers of Attorney previously executed by me to the extent such provisions are inconsistent with this Power of Attorney.

C. Revocation and Duration.

The powers and authority herein granted may be revoked by me by oral or written notice delivered to my Health Care Representative. Prior to such revocation, this Durable Health Care Power of attorney shall remain in effect despite my disability, incapacity or adjudged incompetency.

D. Release.

I release all persons from any liability arising from their reliance on this Power of Attorney if they have no actual knowledge that I have revoked it. I release my Health Care Representative from all liability to me, to my estate, and to any other person for any actions taken by my Health Care Representative hereunder in good faith and based upon the information then available to my Health Care Representative after consultation with my physician or physicians and other relevant health care providers.

E. GeneralPowers of my Health Care Representative:

The above-named Heath Care Representative, whether the original or the successor, shall have full authority to do any lawful act for me or in my name and to make all decisions related to my personal health care, including, but not limited to, the following:

1. To give consent to any medical procedures, tests or treatments, including surgery; to arrange for my hospitalization, convalescent care, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me;

2. To request, receive and review any information regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain such information, and to disclose such information to such persons,

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organizations, firms or corporations as my representative shall deem appropriate;

3. To employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses and therapists for my physical, mental and emotional well-being;

4. To employ and discharge medical personnel and support personnel to provide respite for members of my family who have taken responsibility for my care;

5. To grant releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instruction given by my representative from all liability for damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment;

6. To execute all documents required to admit me to or release me from any health care facility.

7. To delegate all or part of the authority granted hereunder, if my Health Care Representative shall be reasonably unavailable to exercise such authority, to any eligible person whom I have not disqualified herein;

8. To bring a legal action on my behalf to enforce the provisions of this document.

F. <u>Specific Authority of my Health Care Representative to Decide to Withhold or Withdraw Treatment:</u>

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 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. This would include refusal, withdrawal, modification or changing consent to any medical procedures, tests or treatments, as well as hospitalization, convalescent care, hospice or home care which I or my representative may have previously allowed or consented to, including the refusal or withdrawal of artificial means of nutrition and hydration

I authorize my Health Care Representative to exercise my right of privacy to make decisions regarding my medical treatment and my right to be left alone even though the exercise of my right might hasten my death or be against conventional medical advice.

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G. Guidelines for my Health Care Representative's Decisions:

My Health Care Representative must try to discuss a decision to withhold or withdraw treatment with me if I can communicate in any manner, even by blinking my eyes. However, if I am unable to communicate, my Health Care Representative may make such decision for me after consultation with my attorney, 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. To make such a decision my Health Care Representative shall consider:

1. My diagnosis and prognosis;

2. The risks, benefits and burdens to me of treatment;

3. The emotional burdens on my family;

4. The financial burden on my family;

5. My statements of preference regarding health as expressed in this document;

6. Other statements regarding health care I have made, giving most weight to my most recent statements;

7. My ethical and religious principles;

8. The opinions of appropriate family members and others who are close to me as to what I would want done if I were able to express myself.

H. The Authority of my Health Care Representative in Relation to my Health Care Declaration:

I intend for my Health Care Representative to be bound and guided by the provisions I have stated in my Health Care Declaration. However, I recognize that there are circumstances that I cannot anticipate and I have put my complete confidence in my Health Care Representative. Therefore, I authorize third parties, including health care providers, to rely on the decisions of my Health Care Representative even if the decisions of my Health Care Representative are perceived to be inconsistent with or beyond the provisions of my Health Care Declaration if I am unable to consent to or to refuse treatment at that time. In the event my Health Care Representative is unable or unwilling to act during my incapacity, then the foregoing Health Care Declaration shall speak as if I were expressing it at the time.

I. General Provisions:

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1. My Health Care Representative's decision shall be controlling notwithstanding the assertions of other members of my family.

2. I authorize health care providers to rely on my Health Care Representative's decisions just as if I had made them myself and I hereby ratify and confirm all that my Health Care Representative shall do by virtue hereof.

3. I authorize the delivery of this document to any physician and health care facility that may render medical treatment to me and I authorize any physician having custody of this document to release any needed medical information and to deliver any documents and information to any person as may be necessary or desirable to accomplish my intent as expressed herein.

I understand the full import of these Declarations and grant of Health Care Power of Attorney and in witness whereof, I have hereunto directed my sister, Carole Harris, to sign this document on my behalf as a statement of my intent this day of 2014.

Naomi RuthDodson

WITNESSETH:

On the 24th day of Dec, 2014, the Declarant signified to me that this Health Care Declaration and Health Care Power of Attorney was being made by the Declarant freely and voluntarily and, in my presence. The Declarant signed such Declaration and Power of Attorney and I at the Declarant's request and in the Declarant's presence and, in the presence of the other witnesses hereto, signed my name in witness thereof. I further state that the Declarant has been personally know to me, and is believed by me to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant. I am not a parent, spouse, or child of the Declarant, and am not, to the best of my knowledge, entitled to any part of the Declarant's estate and am not directly financially responsible for the Declarant's medical care. I am competent and at least eighteen (18) years old.

Gwendolyn Adell
Witness Signature

6891 Ash Rd
Street Address

Gwendolyn Adell
Witness Printed

Gary IN 46403
City, State, Zip Code

Paula Johnson Roberts
Witness Signature

6900 Stonecrest Run Drive
Street Address

Paula Johnson Roberts
Witness Printed

Nashville, TN 37211-6941
City, State, Zip Code

NRD

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

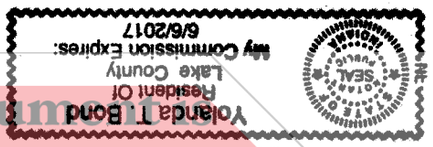
Before me a Notary Public in and for said County and State, personally appeared Naomi Ruth Dodson, who in my presence directed that her sister, Carole Harris, sign this document in my presence and on her behalf thereby acknowledging the intentional and voluntary execution by Naomi Ruth Dodson of the foregoing Health Care Declaration and Health Care Power of Attorney.

Witness my hand and Notarial seal, this 24th day of December, 2014

Commission Expires: 6/6/2017

Yolanda Bond
Notary Public

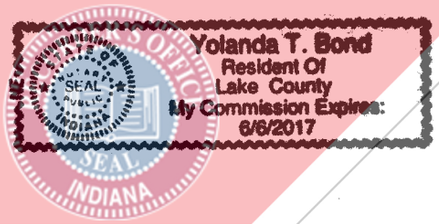
YOLANDA Bond
Name Printed



County of Residence Lake

This instrument prepared by: Attorney Cynthia I. Taylor, 7863 Broadway, Suite 217, Merrillville, Indiana 46410

I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security Number in this document, unless required by law. Cynthia I. Taylor



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