Dependent Gathel Dian Parker

Respondent to Motion of Sommary Judgment

I Gathel Dian Parker X-wife of the Deased Daniel R. Parker Would like to Move for Motion for sommary Judgment in reguards to the Cheasapeak Life Insr. N08110193I Be Declared to rightful Benificiary.

After the Deased Daniel R Parker Passed on Oct the 16th 2016 I Gathel Dian Parker and the Agent the Sold the Life insurance to us. Called Cheasapeak on a 3 way Call to Report the Passing of Mr Parker.
Thay explain every thing thay Would need from me to Collect on the Life ins Policey I followed through an also had a friend and Cousin that Work with insurance Help me fill out every thing She put it in an envelope an I took it to the Postoffice and mail the Policy to them. Over Night Divlery.
I Contacted them about three Weeks later and was told over the Phone thay Couldnt talk to me. I ask to talk

to Someone over them. Thay divided Me to the people over change of Benifacuary. Thay told Me I Was No longer the Benifacuary on the Policy I ask Sence When. Thay said It Was Changed July 15-2015 I ask to Who privalage information in Power of attorney that she recieve from the state of WI. on 3/6/15 Wasnt Not any good My Power of Attourney Being that the Deased and I Was still Married and Speaking and Never even thought of getting a divorce. He had told Me he Was going to Buy a Summer Home up there So We Wouldnt have to pay Motel Bills an Could Stay as long as we Wanted. Thay Was Never No divorce Mention or a Change of Benifacuarys on anydtns. In the EXHIBITS

She also dissuaded him and prohibited him from from talking to me. She Started Carry the Phone to her Bed Rome at Night. The change of Benifacuary Papers are forage By Her Deceas Daniel R Parker Did Not Sign Those Papers.

The Chesapeake Life Insurance Company
P.O. Box 305014
Nashville, TN 37230-5014

Phone:866-215-5343
Fax:803-333-4439

July 16, 2015

DANIEL R PARKER
2586 ZAK LANE
GREEN BAY WI 54304

Insured Name: DANIEL R PARKER
Policy Number: N081101931
Correspondence Number: 12594180

Dear DANIEL R PARKER:

Thank you for contacting The Chesapeake Life Insurance Company. Enclosed is the form necessary to request a beneficiary change. Please complete, sign and date the form and return it to our office.

If you have any questions, please call the Client Service Center at the number above, Monday through Friday from 8:00 AM to 5:00 PM Central Time.

Sincerely,

Client Services

Enclosure(s): Instructions-Beneficiary Change Form
Beneficiary Change Form
Disclosure

Connie Hernandez (Sister of Daniel Parker)
2586 Zak Lane
Green Bay, WI 54304

[redacted]

Exhibit 2 pg 1

The Chesapeake Life Insurance Company

866-215-6343

BENEFICIARY CHANGE REQUEST/Continued

Insured: DANIEL R PARKER	Policy No.: N081101931

CONTINGENT BENEFICIARY 2:		
NAME:		Percentage:
		Telephone Number:
Mailing Address:		
City:	State:	Zip:
SS Number/Tax ID Number:	Date of Birth/Date of Trust:	Relationship to Insured:

Signatures (see instruction sheet for signature requirements):

Individual, Joint or Multiple Owners Signature Section (All owners must sign.)

Owner Signature Daniel R Parker Date Signed 07/21/2015

Joint Owner Signature Connie R Parker Date Signed 07/21/2015

Assignee Signature _____ Date Signed _____

Irrevocable Beneficiary Signature Connie R Parker Date Signed 07/21/2015

Disinterested Witness Signature Helen Mbaugh Date Signed 07/21/2015

Corporate, Partnership or Trust Owned Signature Section

Printed Name of Corporation, Partnership or Full Name of Trust _____ Date of Trust

Printed Name of Corporate Officer or Trustee | Signature of Corporate Officer or Trustee | Title | Date Signed

☐ I am the sole officer of the corporation listed

Printed Name of Corporate Officer or Trustee | Signature of Corporate Officer or Trustee | Title | Date Signed

Spousal Signature Requirements

For the protection of both parties, if the owner resides in a Community Property State, we recommend that the owner's spouse join in signing and dating this form. If the owner resides in CA, ID, NV or WA the owner's spouse must sign and date this form below.

Spouse's Signature _____ Date Signed _____

Notary Signature if required

Subscribed and sworn to before me this _____ day of _____, 2_____

Signature of Notary (official stamp/seal required) My Commission Expires

07295021.00021.00

BEN 002 0914

Pages 1 and 2 Must Be Returned to the Company's Office

Page 2 of 2

Exhibit 2-B

DEED 351 335
Recorded In Above Book and Page
07/17/2014 01:16:38 PM
George T. Hayes, Jr
Chancery Clerk
Newton County, MS

CHANCERY COURT ★ NEWTON COUNTY, MISSISSIPPI ★

Prepared by:
Jason A. Mangum
Attorney at Law
P. O. Box 85
Decatur, MS 39327;
601 635-3432, MSB # 99624

MAKER
DANIEL ROY PARKER
5190 Hickory-Fellowship Road
Hickory, Mississippi 39332
601 646-3050

AGENT
GATHEL DIAN PARKER
5109 Hickory-Fellowship Rd.
Hickory, Mississippi 39332
601 646-3050

GEORGE T. HAYES, JR., CHANCERY CLERK ★ COMMISSION EXPIRES JANUARY 6, 2018 ★ NEWTON ★ MS

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned **DANIEL ROY PARKER,** an adult resident citizen of Newton County, Mississippi, do hereby appoint **GATHEL DIAN PARKER**, to act in my name, place and stead as my true and lawful attorney-in-fact and agent for me, with full authority to exercise the powers set forth below in all matters in which I may be interested or concerned.

I.

POWERS

Powers Generally: I authorize and empower my attorney-in- fact, to enter into and carry out any and every agreement and execute all instruments incidental thereto, with regard to my property, whether real, personal or mixed, or any part thereof, which I may now or hereafter own, and generally to do and perform for me and in my name all acts and things, whatsoever requisite and necessary to be done for the protection of my estate and my best interest, as fully and effectually in all respects as I myself could do if present and competent, including, but not limited to, all of the following specific powers.

Power to Sell: To sell or lease any and every kind of property that I may own now or in the future, whether real, personal, intangible and/or mixed, including, without being limited to, contingent and expectant interests, marital rights, and any rights of survivorship incident to joint tenancy or tenancy by the entirety, upon such terms and conditions and security as my attorney-in-fact shall deem appropriate and grant options with respect to sales thereof and to make such disposition of the proceeds of such sale or leases on my behalf (including expending such proceeds for my benefit) as my attorneys-in-fact shall deem appropriate.

Power to Buy: To buy every kind of property, whether real, personal, intangible and/or mixed, upon such terms and conditions as my attorney-in-fact shall deem appropriate, to obtain options with regard to such purchases, to arrange for appropriate disposition, use, safekeeping and/or insuring of any such property purchased by my attorney-in-fact, to borrow money for the purposes described herein and to secure such borrowing in such manner as my attorney-in-fact shall deem appropriate, and to repay from any funds belonging to me any money borrowed.

STATE OF MISSISSIPPI
COUNTY OF NEWTON
CERTIFIED COPY
I, GEORGE T. HAYES, JR., Clerk of the Chancery Court of said county, do hereby certify that the within instrument is a true and correct copy as same appears of record, in Book 351 Page 335
in this office. Given under my hand and official seal of office this the 17th day of Jan. 20 17
GEORGE T. HAYES, JR., Chancery Clerk
By Samantha D.C.

Power to Invest: To invest and re-invest all or part of my property in any other property or interests in property (including undivided interests), whether real, personal, intangible or mixed, wherever located, including, without being limited to, securities of all kinds, bonds, debentures, notes (secured or unsecured), stocks of corporations regardless of class, real estate or interests in real estate, whether or not productive at the time of investment, and participation in common or pooled trust funds without being limited by statute or rule of law concerning investments by fiduciaries and to control, manage, withdraw, deposit and otherwise deal with all bank accounts, certificates of deposit or other securities or deposits in any bank in which I have such accounts.

Power to Operate Business: To continue the operation of any business belonging to me or in which I have an interest for such time and in such manner as my attorney-in-fact shall deem appropriate, including, but not limited to, hiring and discharging my employees, paying my employee salaries and providing for employee benefits, and employing legal, accounting, financial and other consultants.

Power to Borrow Money: To borrow money for my account upon such terms and conditions as my attorney-in-fact shall deem appropriate, and to secure such borrowing by the granting of security interests in any property or interest in property which I may now or hereafter own.

Power to Make loans: To lend money and property at such interest rate, if any, and upon such terms and conditions, and with such security, if any, as my attorney-in-fact may deem appropriate, and to renew, extend, and modify any such loan or loans that I may have previously made.

Power to Maintain Suit: To commence and prosecute on my behalf, any suits, actions or legal or equitable proceedings for the recovery of any of my lands or for any goods, chattels, debts, damages, etc. and to appear, answer and defend any actions or suits whatsoever which shall be commenced against me with full authority to prosecute, defend, maintain, compromise, settle and/or discontinue the same.

Healthcare decisions: Should I, at anytime hereafter, lack the capacity to make health care decisions for myself, my agent is hereby authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, subject to any instructions hereinafter set forth. My agent's authority shall become effective when my primary physician determines that I am unable to make my own health-care decisions.

My agent shall make health-care decisions for me in accordance with the instructions contained within this power of attorney for health care, and my other wishes, to the extent known to my agents, so long as the same do not conflict with the instructions contained herein. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

I do hereby place full authority in my agent to make any and all health care decisions for me, including but not limited to, the right to:

(a) Consent or refuse to consent to any care, treatment, service, or procedure to maintain diagnose, or otherwise affect a physical or mental condition;

(b) Select or discharge health-care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs or medication, and orders not to resuscitate; and

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

II.

DURABILITY

This power shall not be affected by the subsequent disability, incapacity or incompetence of the undersigned as Principal, and all acts done by my attorney-in-fact pursuant to this Power of Attorney during any period of my disability or incompetence or any uncertainty as to whether I am dead or alive shall have the same effect and inure to the benefit of and bind me, my heirs, distributees, devisees, legatees, and personal representatives as if I were alive, competent, and not disabled.

In the event that it becomes necessary for a guardian or conservator to be appointed for my person or estate, then I, under authority of Miss. Code Ann. §87-3-109, do hereby nominate and appoint my attorney-in-fact, GATHEL DIAN PARKER, to act as the conservator and/or guardian of my estate and person.

III.

REVOCATION, REMOVAL, AMENDMENT AND RESIGNATION

This instrument may be amended or revoked by me, and my Attorney-in-Fact may be removed by me at any time by the execution by me of a written instrument of revocation, amendment, or removal delivered to my Attorney-in-Fact. If this instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records. My Attorney-in-Fact may resign by the execution of a written resignation delivered to me, or if I am mentally incapacitated, by delivery to any person with whom I am residing or who has the care and custody of me.

IV.

REVOCATION OF PREVIOUS POWER OF ATTORNEYS

By this instrument I do hereby revoke any and all previous Powers of Attorney heretofore given by me.

WITNESS MY SIGNATURE, this 7th day of May, 2013.

DANIEL ROY PARKER

STATE OF MISSISSIPPI
COUNTY OF NEWTON

Personally appeared before me, the undersigned authority in and for said county and state, **DANIEL ROY PARKER,** who acknowledged that he signed and delivered the above and foregoing instrument on the day and year therein shown as his own act and deed and for the purposes therein mentioned.

Given under my hand and official seal this 7th day of May 2013.

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 27243 ANN TRAPP Commission Expires Aug. 10, 2013 NEWTON COUNTY

NOTARY PUBLIC

HSHS St.Vincent
St.Mary's
St.Nicholas
St.Clare

Power of Attorney for Health Care Document

Name: Daniel (First) R. (Middle) Parker (Last)

Date of Birth: 12/21/57

Address: 2586 Zak Ln., Green Bay WI 54304

Telephone: (920) 390-2013 Cell: ( ) Work ( )

Document made this 7 day of March (month), 2015 (year).

I, Daniel R. Parker, being of sound mind, intend by this document to create a Power of Attorney for Health Care. My executing this power of attorney is voluntary. I expect to be fully informed about and allowed to participate in health care decisions for myself as long as I have the capacity to do so. For the purposes of this document, health care decision means an informed decision to accept, maintain, discontinue, or refuse any medical care.

Copies of this document have been given to:

1. St Vincent
2. Physician's Office
3. Connie
4. Phillip
5.

If a new document is created, all previous copies should be replaced with a copy of the new one.

Notice to Person Making this Document:

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

In some cases your health care providers may not have had the opportunity to establish a long-term relationship with you and are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to

EXHIBIT C

discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified.

You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care providers and any other person to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

Part I – Appointing a Health Care Agent

If I am no longer able to make health care decisions for myself, this document names the person I choose as my agent to make these choices for me. This person will make my health care decisions if I am determined to be incapable to make health care decisions as defined by state law.

For the purpose of this document, 'incapacity' exists if two physicians or a physician and a psychologist have personally examined me and signed a statement that specifically expresses their opinion that I am unable to receive and evaluate information effectively or to communicate decisions. A copy of that statement must be attached to this document. If I am unable, due to my incapacity, to make health care decisions, my health care agent is instructed to make health care decisions for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes.

Note: When selecting someone to be your health care agent, choose someone who knows you well, whom you trust, who is willing to respect your views and values, agrees to carry out your wishes, and is able to make difficult decisions in stressful situations. Take time to discuss this document and your views with the person you pick to be your health care agent and give him or her a copy of this document. Your health care agent must be at least 18 years of age and should not be your health care provider, an employee of that health care provider, an employee of a health care facility in which you are a patient or resident, or a spouse of any of those providers or employees, unless the health care provider, employee or spouse of the provider or employee, is your relative.

The person I name as my health care agent is:

Name: Connie R. Alexandre Relationship: Sister

Address: W1052 Cty Rd EE DeKorn WI 54115

Phone: Home (920) 393-4247 Cell (920) 370-2013 Work ( ) –

If the health care agent listed above is ever unable or unwilling to do so, then I name as my health care agent:

Name: Phillip D. Alexandre Relationship: Brother in law

Address: W1052 Cty Rd EE DeKorn WI 54115

Phone: Home (920) 393-4247 Cell (920) 370-2013 Work ( ) –

If neither of the health care agents listed above is ever unable or unwilling to do so, then I name as my health care agent:

Name: None Relationship:

Address:

Phone: Home ( ) Cell ( ) Work ( )

Part II – General Authority of the Health Care Agent

Subject to any limitations in this document, if I ever have incapacity, my health care agent has the authority to request and review all information, oral and written, regarding my physical and mental health. This includes signing consent forms to release any medical information to other parties. I will discuss my desires with my health care agent and believe he or she is willing to carry them out.

Note: Please check yes or no in the boxes below. If you do not mark a box in a section and make no clear choice, Wisconsin law states that your choice is considered to be "No".

1. **Admission to a nursing home or community based residential facility (CBRF):**
   My health care agent has authority to allow admission to a facility to receive long term nursing care if necessary. (Note: A health care agent automatically has authority to allow admission to a facility for short-term stays.)

   [X] Yes [ ] No Nursing Home

   [X] Yes [ ] No Community Based Residential Facility

2. **Provision of a feeding tube:**
   My health care agent has authority to have a feeding tube or IV hydration withheld or withdrawn from me, unless my physician has advised that in his or her professional judgment this will cause me pain or will reduce my comfort.

   [X] Yes [ ] No

3. **Making decisions if I am pregnant:**
   My health care agent has authority to make decisions for me if I am pregnant.

   [ ] Yes [ ] No [X] N/A

Limitations on Mental Health Treatment

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, to an intermediate care facility for persons with mental retardation, or a state treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

Part III – Statement of specific Desires, Special Provisions or Limitations

My health care agent must make health care decisions for me based on the instructions I provide. He or she must act in my best interest consistent with the principles I have stated in this document, or in accord with any wishes I have made known to him or her. Most of what I state here is general in nature, since I cannot anticipate all possible circumstances of a future illness. If I have not given specific instructions, then my health care agent must make decisions consistent with my wishes and beliefs, in accordance with the principles set forth below:

1. *Ordinary* or *proportionate* means shall be used to preserve my life. *Proportionate* means are those that offer a reasonable hope of benefit, are reasonably expected to prolong my life, do not entail an excessive burden or impose excessive expense on my family or community, and do not cause significant physical discomfort.
2. Medical treatments that are *extraordinary* or *disproportionate* means of preserving my life may be withdrawn or avoided. *Disproportionate* means of preserving my life may be withdrawn or avoided. *Disproportionate* means are those that do not offer a reasonable hope of benefit, are not reasonably expected to prolong my life, entail an excessive burden or impose excessive expense on my family or the community, or cause significant physical discomfort.
3. A. In principle, there is an obligation to provide me food and water, including medically assisted nutrition and hydrations if I cannot take food orally. This obligation extends to chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") where I am reasonably expected to live indefinitely, if given such care.
   B. Medically assisted nutrition and hydration become *optional* when they cannot reasonably be expected to prolong my life, do not offer a reasonable hope of benefit, when they would be excessively burdensome or impose excessive expense on my family or my community, or would cause significant physical discomfort.
4. I should not be deprived of consciousness without a compelling reason.
5. I oppose suicide and euthanasia. Treatment or support must not be provided or withheld for the purpose of causing my death.
6. I desire the use of medication or procedures necessary for my comfort. Medicines capable of alleviating or suppressing pain may be given to me, even if this therapy **may indirectly** shorten my life. However, I do not wish to receive such treatment when given for the intent of hastening my death.
7. If my death is imminent, I desire that those treatments which maintain a burdensome prolongation of my life be withdrawn or avoided, unless those responsible for my care judge that there are special and significant reasons why I should continue to receive such treatment.

I also desire that the following be adhered to regarding my health care decisions:_____

Please check your choice, if any, in the boxes below.

☐ For Catholics: I desire that efforts be made so that I receive the Sacraments of Reconciliation, Anointing of the Sick and Eucharist as Viaticum.

☒ I desire that my spiritual/pastoral leader is contacted. Methodist

[X] **If my life is at an end and there is no reasonable hope for recovery, the medical interventions are non-beneficial, the burdens outweigh the benefits, and are prolonging my dying process, I would like all life-support systems removed. I wish to be kept comfortable and pain free.**

Donation of My Organs or Tissue (Optional): please check your choice in the box:

[ ] I intend to donate **only** the listed organs and/or tissues _____.

[ ] I intend to donate **any** organs or tissue.

[X] **I do not** intend to donate any organ or tissue.

[ ] I intend to donate my body to medical science. **Note**: Donating your body to medical science needs to be arranged ahead of time.

Part IV – Making the Document Legal

This document created pursuant to Chapter 155 of the Wisconsin Statutes must be signed and dated in the presence of two witnesses with both witnesses signing at the same time. I am thinking clearly and agree with everything that is written in this document and have made this document willingly.

Signature _____ Date 3/7/15

Statement of Witnesses:

I know the person creating this document and believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document and believe he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not a health care agent appointed by the person creating this document.
- Not related to this person by blood, marriage, or adoption.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than social worker or chaplain) of a health care provider directly serving this person at this time.
- Not aware that I am entitled to or have a claim against this person's estate.

Witness #1: Date 3/7/15

Signature _____

Print Name Mary Salm BCC

Address 835 S. Van Buren St. Green Bay, WI 54301

Witness #2: Date 3/7/15

Signature _____

Print Name Kristine Miller MSW, CADC

Address 835 So Van Buren Green Bay WI 54301

Statement of Health Care Agent and Alternate Health Care Agent

I understand that Daniel R. Parker has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions. The person creating this document has discussed his or her desires regarding health care decisions with me.

Agent's Signature/Date
Connie Akenaadone 03/07/2016

Alternate's Signature/Date
Phillip

Alternate's Signature/Date

This document includes information from the State of Wisconsin form as well as the addendum by the five Catholic Bishops' of Wisconsin (3/5/14).

Revised 1/22/15

WISCONSIN STATUTORY POWER OF ATTORNEY FOR FINANCES AND PROPERTY
IMPORTANT INFORMATION

This Power of Attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes.

This Power of Attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the Power of Attorney or the agent resigns or is unable to act for you.

Recording Area ↑

Name and Return Address

Daniel R. Parker
25862 Oak Ln.
Green Bay, WI. 54115

6H-1974
Parcel Identification Number (if any)

Your agent is entitled to reasonable compensation unless you state otherwise in the special instructions.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a co-agent in the special instructions. Co-agents are not required to act together unless you include that requirement in the special instructions.

If your agent is unable or unwilling to act for you, your Power of Attorney will end unless you have named a successor agent. You may also name a 2nd successor agent.

This Power of Attorney becomes effective immediately unless you state otherwise in the special instructions. This Power of Attorney does not revoke any Power of Attorney executed previously unless you so provide in the special instructions.

If you revoke this Power of Attorney, you should notify your agent and any other person to whom you have given a copy. If your agent is your spouse or domestic partner and your marriage is annulled or you are divorced or legally separated or the domestic partnership is terminated after signing this document, the document is invalid.

If you have questions about the Power of Attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

Exhibit 1

DESIGNATION OF AGENT

I, Daniel e Parker (name of principal), name the following person as my agent:

Name of agent: Connie Skenandore

Agent's address: 2558 Zak Ln, Green Bay WI 54304

Agent's telephone number: 920/370/2013

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of successor agent: Phillip Skenandore

Successor agent's address: 2558 Zak Ln

Successor agent's telephone number: 920-370-2013

If my successor agent is unable or unwilling to act for me, I name as my 2nd successor agent:

Name of 2nd successor agent: Shirley Hill

Second successor agent's address: 2828 Commissoner st Oneida, WI 54155

Second successor agent's telephone number: 920-869-1506

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined (see Appendix) in the Uniform Power of Attorney for Finances and Property Act in chapter 244 of the Wisconsin statutes:

(INITIAL each subject you want to include in the agent's general authority.)

dlp	Real property
dlp	Tangible personal property
	Stocks and bonds
dlp	Commodities and options
dlp	Banks and other financial institutions
	Operation of entity or business
dlp	Insurance and annuities
dlp	Estates, trusts, and other beneficial interests
dlp	Claims and litigation
dlp	Personal and family maintenance
dlp	Benefits from governmental programs or civil or military service
dlp	Retirement plans
dlp	Taxes

IMPORTANT INFORMATION FOR AGENT
AGENT'S DUTIES

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the Power of Attorney is terminated or revoked. You must do all the following:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest.

(2) Act in good faith.

(3) Do nothing beyond the authority granted in this Power of Attorney.

(4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

Janet Parker (principal's name) by Connie Alexander (your signature) as agent

Unless the special instructions in the Power of Attorney state otherwise, you must also do all the following:

(1) Act loyally for the principal's benefit.

(2) Avoid conflicts that would impair your ability to act in the principal's best interest.

(3) Act with care, competence, and diligence.

(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal.

(5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest.

(6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

TERMINATION OF AGENT'S AUTHORITY

You must stop acting on behalf of the principal if you learn of any event that terminates this Power of Attorney or your authority under this Power of Attorney. Events that terminate a Power of Attorney or your authority to act under a Power of Attorney include all the following:

(1) Death of the principal.

(2) The principal's revocation of the Power of Attorney or your authority.

(3) The occurrence of a termination event stated in the Power of Attorney.

(4) The purpose of the Power of Attorney is fully accomplished.

(5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the special instructions in this Power of Attorney state that such an action will not terminate your authority.

(6) If you are the principal's domestic partner and your domestic partnership is terminated, unless the special instructions in this Power of Attorney state that such an action will not terminate your authority.

LIABILITY OF AGENT

The meaning of the authority granted to you is defined in the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes. If you violate the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

OPTIONAL SIGNATURE OF AGENT

I have read and accept the duties and liabilities of the agent as specified in this Power of Attorney.

Agent's signature Connie Ikenander Date _____

Attached:

(1) Agent's certification as to the validity of Power of Attorney for Finances and Property and agent's authority (Optional).
(2) Appendix: Power of Attorney for Finances and Property Statutory Authority Definitions (Optional).

The following optional form may be used by an agent to certify facts concerning a power of attorney for finances and property:

AGENT'S CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY FOR FINANCES AND PROPERTY AND AGENT'S AUTHORITY

State of: Wisconsin

County of: Brown.

I, Connie Skenandore (name of agent), certify under penalty of perjury that Daniel Parker (name of principal) granted me authority as an agent or successor agent in a power of attorney dated _____.

I further certify that to my knowledge:

(1) The principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney, and the power of attorney and my authority to act under the power of attorney have not terminated.

(2) If the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred.

(3) If I was named as a successor agent, the prior agent is no longer able or willing to serve.

(4) _____
(insert other relevant statements)

SIGNATURE AND ACKNOWLEDGMENT

Agent's signature Connie Skenandore Date 03/06/2015

Agent's name printed Connie Skenandore

Agent's address: 2586 Oak Lane, Green Bay, WI 54304

Agent's telephone number: 920-370-2013

State of: Wisconsin County of: Brown

This document was acknowledged before me on

Date 3/6/15 by (name of agent) Connie Skenandore

CYNTHIA NIELSEN NOTARY PUBLIC (Seal, if any) STATE OF WISCONSIN

Signature of notary Cynthia Nielsen

Name of notary (typed or printed) Cynthia Nielsen

My commission expires: 2/22/2019

This document prepared by: Connie Skenandore

LIMITATION ON AGENT'S AUTHORITY

An agent who is not my spouse or domestic partner MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the special instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions in the following space

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the special instructions.

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of nominee for guardian of my estate: Connie Skenandore

Nominee's address: 2586 ZAK LN. Green Bay, WI 54304

Nominee's telephone number: 920/370/2013

Name of nominee for guardian of my person: Connie Skenandore

Nominee's address: 2586 ZAK LN, Green Bay, WI 54304

Nominee's telephone number: 920/370/2013

RELIANCE ON THIS POWER OF ATTORNEY FOR FINANCES AND PROPERTY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows that the power of attorney has been terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

Your signature _____ Date 03/26/2015

Your name printed Daniel R Parker

Your address: 2586 Zak Lane, Green Bay, WI 54304

Your telephone number: 920-

State of: Wisconsin County of: Brown

This document was acknowledged before me on

Date 3/26/15 by name of principal Daniel R. Parker

CYNTHIA NIESEN NOTARY (Seal, if any) PUBLIC STATE OF WISCONSIN

Signature of notary _____

Name of notary (typed or printed) Cynthia Niesen

My commission expires: 2/22/2019

This document prepared by: Connie Abrahamson

WISCONSIN CERTIFICATE OF VITAL RECORD

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
ORIGINAL CERTIFICATE OF DEATH
FACT OF DEATH

STATE FILE DATE: OCTOBER 13, 2016
STATE FILE NUMBER: 2016039134

1. DECEDENT'S NAME			2. SOCIAL SECURITY NUMBER	3. DATE PRONOUNCED DEAD
First: DANIEL	Middle: ROY	Last: PARKER	[redacted]	OCTOBER 06, 2016

4. TIME PRONOUNCED DEAD (24hr)	5. AGE	6. DATE OF BIRTH	7. SEX	8. CITY, VILLAGE, OR TOWNSHIP OF DEATH	9. COUNTY OF DEATH
08:10	[redacted]	[redacted]	MALE	GREEN BAY (CITY)	BROWN

10. PLACE OF DEATH	11. FACILITY NAME AND ADDRESS OF DEATH
DECEDENT'S RESIDENCE - HOSPICE CARE	[redacted]

12. RESIDENCE ADDRESS	13. RESIDENCE CITY, VILLAGE, OR TOWNSHIP	14. RESIDENCE COUNTY	15. RESIDENCE STATE
[redacted]	GREEN BAY (CITY)	BROWN	WISCONSIN

16. MARITAL STATUS	17. WI DOMESTIC PARTNERSHIP	18. SURVIVING SPOUSE'S BIRTH NAME	19. STATE OF BIRTH	20. DECEDENT'S BIRTH LAST NAME
DIVORCED	NO		WISCONSIN	PARKER

21. FATHER'S BIRTH NAME	22. MOTHER'S BIRTH NAME
ANDREW PARKER	SHIRLEY KUROWSKI

23. INFORMANT'S NAME	24. INFORMANT'S MAILING ADDRESS
CONNIE SKENANDORE	[redacted]

25. NAME AND ADDRESS OF FUNERAL FACILITY	26. FUNERAL DIRECTOR'S NAME	27. DATE SIGNED
RYAN FUNERAL HOME, PO BOX 5336, DE PERE, WI 54115	VANDEN AVOND, JOSEPH P	OCTOBER 12, 2016

28. MANNER OF DEATH	29. TYPE OF MEDICAL CERTIFIER	30. MEDICAL CERTIFIER'S NAME AND TITLE	31. DATE SIGNED
NATURAL	PHYSICIAN	LYNN BUDZAK, MD	OCTOBER 11, 2016

32. DATE OF DEATH	33. TIME OF DEATH (24hr)	34. MEDICAL CERTIFIER'S MAILING ADDRESS
OCTOBER 06, 2016	08:10	2851 UNIVERSITY AVE, GREEN BAY, WI 54311

EXTENDED FACT OF DEATH

35. USUAL OCCUPATION	36. KIND OF BUSINESS/INDUSTRY	37. EVER IN US ARMED FORCES	38. DECEDENT TRIBAL MEMBER	TRIBE NAME(S):
SARGEANT	MILITARY	YES	YES	ONEIDA TRIBE OF WISCONSIN

39. METHOD OF DISPOSITION	40. PLACE AND LOCATION OF DISPOSITION
CREMATION	RELIANCE CREMATORY, DE PERE, WISCONSIN

41. PART I. The conditions listed are the diseases, injuries, or complications that caused death. Conditions leading to the immediate cause are listed sequentially and the underlying cause is listed last. — Interval Between Onset and Death

Immediate Cause (a)	[redacted]
Due to or as a consequence of (b)	[redacted]
Due to or as a consequence of (c)	[redacted]
Due to or as a consequence of (d)	

41. PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.

42. AUTOPSY PERFORMED	43. DATE OF INJURY	44. TIME OF INJURY (24hr)	45. INJURY AT WORK	46. PLACE OF INJURY
NO				

47. LOCATION OF INJURY	48. COUNTY OF INJURY

49. IF INJURY STATED ANYWHERE IN CAUSE OF DEATH (Part I or Part II), DESCRIBE HOW IT OCCURRED.

NO AMENDMENTS PRESENT 1050401

I certify that this document contains a true and correct reproduction of facts on file with the Wisconsin Vital Records Office.

16377210

Date Issued: OCTOBER 18, 2016

CATHY WILLIQUETTE LINDSAY
BROWN COUNTY REGISTER OF DEEDS

WARNING! IT IS A FELONY TO COPY OR REPRODUCE THIS CERTIFICATE. STATE STATUTE 69.24(1)

THIS CERTIFICATE HAS A BLUE/WHITE BACKGROUND ON THE FACE AND TWO RAISED SEALS - THE PAPER CONTAINS A VISIBLE CHAIN LINE WATERMARK - HOLD TO LIGHT TO VERIFY

EXHIBIT
tabbies
D

0000784.0000265

The Chesapeake Life Insurance Company

Claimant's Statement

In order to process your claim as quickly as possible, we need some information about you and the Insured. Please submit the original insurance policy(ies), a certified death certificate that includes the cause and manner of death, and the original Claimant's Statement(s). Only one certified death certificate is needed to process your claim. Each Claimant must submit their own Claimant's Statement. If you need assistance in completing this form, the company or one of its representatives will assist you.

A. Insured's Information

1. Name: Daniel R Parker Date of Death: 10/06/2016
   Other names used by the Insured: _____
2. Please list all policy/contract numbers with our company on which you are filing a claim:
   N08110193 1 _____ _____
3. **Please note:** All policies listed above should be submitted with your claim. If policies are not attached, please state why:
   Attached
4. Address: _____ _____
   Street Address/P.O. Box City, State and Zip Code
5. Marital Status:
   Single ☐ Married ☐ Widowed ☐ Separated ☑ Divorced ☐ Other ☐ (specify) _____
6. Date of Birth: [redacted] Place of Birth: Wisconsin
7. Cause of Death: [redacted]
8. Manner of Death:
   Natural ☐ Homicide ☐ Accident ☐ Suicide ☐ Other (specify) _____
9. Occupation: Disabled Date Last Worked: Don't know
10. Employer Name: Crackle Barrel Employer Phone Number: _____
11. Employer Address: Vicksburg MS _____

B. Claimant's Information

1. Name: Gathel D Parker Relationship to Insured: X Wife
   Sex: Male ☐ Female ☑
2. Date of Birth: [redacted]
3. In what capacity are you claiming the death benefit? **Please check the box that applies to you.**
   Named Beneficiary ☑ Executor/Administrator ☐ Legal Guardian ☐ Trustee ☐ Other ☐ (specify)
   _____
   Mailing Address: [redacted]
   Street Address/P.O. Box City, State and Zip Code
4. Phone Numbers: (WK) _____ (HM) _____ (CELL) [redacted]
5. Email Address: [redacted]
6. Please indicate preferred method of communication: Mail ☐ Phone ☑ Email ☐
7. Citizenship, If not U.S.A.: _____

C. Information about other insurance

List any additional life insurance on the life of the Insured.
None

D. Settlement Options

Installment Options Settlement Descriptions

All or part of the proceeds of the policy may be paid under any one or a combination of the following options. Please review Insured's policy for the specific options available to you.

- **Income for Fixed Period:** Payments, determined from the table provided in the policy, guaranteed for the number of years chosen.

(continued on next page)

EXHIBIT E

(Section D. continued)

- Life Income: Payments, determined from the table in the policy, for the Option elected, based on the payee's sex and age nearest birthday on the date the first payment becomes due. Life income options available are (1) payments only while the payee is alive; or (2) payments guaranteed for 10 years; then continuing while the payee is alive.
- Interest Income: We will hold the proceeds until withdrawn by the payee. The payee may withdraw all or part of the proceeds at any time. Any proceeds not withdrawn will be paid at the death of the payee. Interest on any unpaid balance will be accumulated or paid annually, semi-annually, quarterly or monthly, as selected.
- Income of Fixed Amount: We will pay the proceeds in installments of a selected amount until all of the proceeds and interest are fully paid.
- Annuity: We will apply the proceeds as a single premium to purchase an annuity payable to one or two payees. The annuity payments will continue while the payee is living, or if an annuity for two payees is selected, payments will continue while either is still living. The amount of each annuity payment will not be less than the amount of the payment which proceeds of this policy would otherwise provide based on the annuity rates we are using on the date the proceeds of this policy become payable. If at any age the amount of the equal installment payments is the same for more than one period certain, payment will be made as if the longer period certain was chosen.

Any other reasonable method of settlement may be arranged subject to our agreement.

If you prefer a settlement in accordance with any of the installment options as indicated above, please state which option. If you do not indicate your preference, a Lump-Sum Payment will be issued:
Lump Sum

E. Request for Taxpayer Identification Number and Certification

☐ Check this box ONLY if you are NOT a U. S. Citizen or resident or otherwise not subject to U.S. taxation. **If this box is checked, STOP HERE and complete an IRS W-8BEN form.**

Social Security Number: [redacted]
OR
Employer, Trust, or Estate Tax Identification Number: ______-______

Under the penalties of perjury, I certify that:
The number shown above is the correct taxpayer identification number for the individual/entity claiming the proceeds (or I am waiting for a number to be issued) AND (please check one of the following in order to receive the death benefit proceeds):

☑ **I am NOT subject to Backup Tax Withholding because:**
a) I am exempt from Backup Tax Withholding, or
b) I have not been notified by the IRS that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or
c) The IRS has notified me that I am no longer subject to Backup Tax Withholding. (Does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends).

☐ **I am subject to Backup Tax Withholding.**

Also, please check the box below if applicable:
☐ **I am a U.S. person (including a U.S. resident alien).**

(continued on next page)

0000784.0000268

(Section E. continued)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed & Dated at: Meridian, MS (City, State) this 14 (Day) day of Nov. (Month), 2016 (Year)

Signature of Claimant, Trustee, Executor or Signing Officer

X Gathel D Parker

F. Claimant's Signature

Any person who knowingly and with intent, defrauds or deceives an insurance company by submitting or filing a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, may be guilty of insurance fraud, which may be a crime and may be subject to criminal and/or civil penalties.

By signing below, I attest that the information in this Claimant's Statement is complete and true to the best of my knowledge, and that I have read and understand the Fraud Warning Notice set out on Form W11D047 for my state of residence, if any.

Signed & Dated at: Meridian, MS (City, State) this 14 (Day) day of Nov. (Month), 2016 (Year)

Signature of Claimant, Trustee, Executor or Signing Officer: X Gathel D Parker

Claimant's Printed Name: Gathel Parker

Signature of Witness: X Elsie Williams

Witness' Printed Name: Elsie Williams

For contracts issued in and residents of Illinois only:
A valid claim will include interest due and payable from the date of death at a rate of 10% if we do not pay the claim within 31 days from the latest of 1) the date that we receive proof of death, 2) the date we receive sufficient information to determine our liability and the appropriate beneficiary(ies) entitled to the proceeds; or 3) the date that any legal impediments are resolved.

For Vermont contracts only:
Pursuant to Vermont law, interest will accrue on the proceeds from the date of death of the insured to date of payment at the rate of 6.00%.

After the fact that Cheasapeak got
What Connie Skeanadore told them was
a lost policy from me, an I claimed the
Insurance money in EXHiBit D
Then on December 13 th Cheasapeak
Life Can inform me Gathel Dian
Parker That I was no longer the
Beneficiary of this Policy. If I felt
different Please inform them.
I had No Idea Who changed it
they didnt Send me any paper EXHIBIT F
Work With my husband Signture
on it or I could have Said OK the
Gave it to his Sister and it would
Have been over. But in November
I was recieving Her Mail at my
address and I Call Cheasepeak and
Ask them The Beniffaciary has been
Changed But the address hasnt. It
Mail Still comming to my address
in C/o of Gathel Parker. there
is 3 EXHIBITS of it.
Then Finally Mrs Connie Skeanadore
Decides to Clame Policy No81101931
On 9-2-17 from Cheasapeak Life ins
EXHiBiT G

The Chesapeake Life Insurance Company
P.O. Box 1417
Jacksonville, IL 62651-1417

Phone: 866-215-5343
Fax: 803-333-4458

December 13, 2016

GATHEL D PARKER
[redacted]

Insured Name: DANIEL PARKER
Policy Number: N081101931
[redacted]

Dear Ms Parker,

We are writing in response to your notification of the death of DANIEL PARKER. Our sincere condolences go to the family for their loss.

Upon review of our records we do not find you listed as a beneficiary of this policy. If you believe that we have reached this conclusion in error, please provide us with any documentation to the contrary that you may have.

Due to privacy laws, we are prohibited form providing personal information relative to this policy to anyone other than the policy owner, the executor of the policy owner's estate, or the beneficiary(ies) themselves. Our records do not include a current address for the beneficiary. If you know who the beneficiary is, please have him/her contact us directly.

If you have any questions, please call the Client Service Center at the number above, Monday through Friday from 8:00 AM to 5:00 PM Central Time.

Sincerely,

REVOCABLE
Claims Services

EXHIBIT
tabbies
F

The Chesapeake Life Insurance Company
P.O. Box 1417
Jacksonville, IL 62651-1417

Phone: 866-215-5343
Fax: 803-333-4458

October 13, 2016

CONNIE R SKENANDORE
C/O GATHEL PARKER
5190 HICKORY FELLOWSHIP RD
HICKORY MS 39332

Insured Name: DANIEL R PARKER
Policy Number: N081101931
Correspondence Number: 01012558

Dear Ms. Skenandore,

On behalf of the Company, we wish to extend our condolences. To apply for benefits, we need the following information:

- The enclosed Claimant Statement completed and **signed by the named beneficiary**. Signed signature page must be returned with the completed Claimant Statement. If the beneficiary has had a change in name, we will need a copy of the applicable marriage license, divorce decree or similar legal documents. For settlement options, please refer to the corresponding section of the claim form.

- **Certified death certificate** of the deceased. This should indicate cause of death, manner of death, date of birth and Social Security Number.

- Return of the original policy.

- Beneficiary(ies) death certificate, if the beneficiary is deceased.

- To assist us in our review of this pending claim, please provide us with the address and phone number for Connie R. Skenandore.

If benefits are payable to the Estate, Trust, Contingent Beneficiary or Minor children, please refer to the instructions page of the claim form. If benefits are collaterally assigned to a bank or creditor, a release of assignment or a statement from the assignee on their letterhead stating the amount claimed is needed. An officer of the Corporation must sign on behalf of the Corporation. Please submit legal documentation listing the officers who are currently authorized to sign documents relating to the referenced insurance contract on behalf of the company.

If you have any questions, please call the Client Service Center at the number above, Monday through Friday from 8:00 AM to 5:00 PM Central Time.

Sincerely,

D Pond

EXHIBIT I

The Chesapeake Life Insurance Company
P.O. Box 1417
Jacksonville, IL 62651-1417

Phone: 866-215-5343
Fax: 803-333-4458

October 13, 2016

CONNIE R SKENANDORE
C/O GATHEL PARKER
5190 HICKORY FELLOWSHIP RD
HICKORY MS 39332

Insured Name: DANIEL R PARKER
Policy Number: N081101931
Correspondence Number: 01012558

Dear Ms. Skenandore,

On behalf of the Company, we wish to extend our condolences. To apply for benefits, we need the following information:

- The enclosed Claimant Statement completed and **signed by the named beneficiary**. Signed signature page must be returned with the completed Claimant Statement. If the beneficiary has had a change in name, we will need a copy of the applicable marriage license, divorce decree or similar legal documents. For settlement options, please refer to the corresponding section of the claim form.
- **Certified death certificate** of the deceased. This should indicate cause of death, manner of death, date of birth and Social Security Number.
- Return of the original policy.
- Beneficiary(ies) death certificate, if the beneficiary is deceased.
- To assist us in our review of this pending claim, please provide us with the address and phone number for Connie R. Skenandore.

If benefits are payable to the Estate, Trust, Contingent Beneficiary or Minor children, please refer to the instructions page of the claim form. If benefits are collaterally assigned to a bank or creditor, a release of assignment or a statement from the assignee on their letterhead stating the amount claimed is needed. An officer of the Corporation must sign on behalf of the Corporation. Please submit legal documentation listing the officers who are currently authorized to sign documents relating to the referenced insurance contract on behalf of the company.

If you have any questions, please call the Client Service Center at the number above, Monday through Friday from 8:00 AM to 5:00 PM Central Time.

Sincerely,

D Pond

EXHIBIT 2

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

Any person who, knowingly and with intent to defraud, deceive, or injure an insurance company, files a claim containing false, incomplete, fraudulent, or misleading information, may be prosecuted under state law and may be subject to fines and/or confinement in prison:

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to civil and criminal penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false incomplete, or misleading information is guilty of a felony of the third degree.

HAWAII: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false or incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false o fraudulent claim for payment of a loss or benefit or knowingl presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits

MARYLAND: Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willingly presents false information in an application for insurance is guilty of a crime and is subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claims for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years. If extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or a fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Chesapeake Life Insurance Company
P.O. Box 305014
Nashville, TN 37230-5014

Phone:866-215-5343
Fax:803-333-4439

November 04, 2016

CONNIE R SKENANDORE
C/O GATHEL PARKER
5190 HICKORY FELLOWSHIP RD
HICKORY MS 39332

Insured Name: DANIEL R PARKER
Policy Number: N081101931
Correspondence Number: 13317578

Dear CONNIE R SKENANDORE:

Thank you for contacting The Chesapeake Life Insurance Company. We are writing in response to your inquiry on the above-referenced policy.

Enclosed is a copy of the letter you requested.

If you have any questions, please call the Client Service Center at the number above, Monday through Friday from 8:00 AM to 5:00 PM Central Time.

Sincerely,

Client Services

Enclosure(s): Requested Documents

EXHIBIT 3

Claims Services

Enclosure(s): NONCONTESTABLE CLAIM FORM

The Chesapeake Life Insurance Company

Instructions and Definitions for Claimant's Statement

Please read before completing any part of these forms. Every question must be answered completely. The Company reserves the right to require or obtain further information should it be deemed necessary.

Proof of Death – In ordinary cases, the required proofs of death are as follows: *Certified death certificate for the Insured and completion of this Claimant's Statement by the appropriate party.* This Statement must be executed by the person or persons to whom the proceeds are payable. Each Claimant must submit their own claim form.

Certified Death Certificate – The certified death certificate should list a cause and manner of death. Please do not send in a copy as it can delay the processing of your claim. An original certified death certificate should have a notarized seal or watermark. When the death certificate lists the cause and/or manner of death as "pending", the finalized amended death certificate must be furnished before the claim can be processed.

Other Names Used by the Insured and/or Claimant – List any and all names used by the Insured and/or Claimant, including but not limited to: any alias used by the Insured and/or Claimant, maiden name, hyphenated name, nicknames, or any derivative of the Insured's and/or Claimant's first, middle, or last name including different spellings commonly incurred by the Insured and/or Claimant. We may require additional proof of name change (e.g. marriage license, divorce decree, certification of name change, etc.).

Minor Beneficiaries/Claimants – When the proceeds are payable to a minor, Section B of the Claimant's Statement must contain the minor beneficiary's information. The signature section of the form must be signed by the Guardian. Please furnish the certified court appointed Guardianship papers for the Estate of each minor child. Custody papers are not acceptable.

Estate as the Beneficiary – When the proceeds are payable to an individual's Estate, the Claimant's Statement must be executed by the court appointed Executor/Executrix, Administrator, or Personal Representative. Please furnish the certified court appointed Letters Testamentary/Letters of Administration for the Estate.

Trust as the Beneficiary – When proceeds are payable to a Trust, the Claimant's Statement must be executed by the current Trustee(s) of the Trust. A Certification of Trust form must also be completed, which we will provide to you. Please furnish a copy of the Trust Agreement and any amendments to the Trust.

Please note: **If death was due to a suicide, homicide, or accident, please furnish a copy of the autopsy report and a copy of the investigating officer's report.**

The Chesapeake Life Insurance Company

Claimant's Statement

In order to process your claim as quickly as possible, we need some information about you and the Insured. Please submit the original insurance policy(ies), a certified death certificate that includes the cause and manner of death, and the original Claimant's Statement(s). Only one certified death certificate is needed to process your claim. Each Claimant must submit their own Claimant's Statement. If you need assistance in completing this form, the company or one of its representatives will assist you.

A. Insured's Information

1. Name: _____ Date of Death: _____
   Other names used by the Insured: _____
2. Please list all policy/contract numbers with our company on which you are filing a claim:
   _____ _____ _____
3. **Please note**: All policies listed above should be submitted with your claim. If policies are not attached, please state why:
   _____ _____
4. Address: _____ _____ _____
   Street Address/P.O. Box City, State and Zip Code
5. Marital Status:
   Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other ☐ (specify) _____
6. Date of Birth: _____ Place of Birth: _____
7. Cause of Death: _____
8. Manner of Death:
   Natural ☐ Homicide ☐ Accident ☐ Suicide ☐ Other (specify) _____
9. Occupation: _____ Date Last Worked: _____ _____
10. Employer Name: _____ Employer Phone Number: _ _____
11. Employer Address: _____ _____

B. Claimant's Information

1. Name: _____ Relationship to Insured: _____
2. Date of Birth: _____ Sex: Male ☐ Female ☐
3. In what capacity are you claiming the death benefit? **Please check the box that applies to you.**
   Named Beneficiary ☐ Executor/Administrator ☐ Legal Guardian ☐ Trustee ☐ Other ☐ (specify)
   _____
   Mailing Address: _____ _____
   Street Address/P.O. Box City, State and Zip Code
4. Phone Numbers: (WK) _____ (HM) _____ (CELL) _____
5. Email Address: _____
6. Please indicate preferred method of communication: Mail ☐ Phone ☐ Email ☐
7. Citizenship, if not U.S.A.: _____

C. Information about other insurance

List any additional life insurance on the life of the Insured.

_____

D. Settlement Options

Installment Options Settlement Descriptions

All or part of the proceeds of the policy may be paid under any one or a combination of the following options. Please review Insured's policy for the specific options available to you.

- **Income for Fixed Period**: Payments, determined from the table provided in the policy, guaranteed for the number of years chosen.

(continued on next page)

(Section D. continued)

- **Life Income**: Payments, determined from the table in the policy, for the Option elected, based on the payee's sex and age nearest birthday on the date the first payment becomes due. Life income options available are (1) payments only while the payee is alive; or (2) payments guaranteed for 10 years; then continuing while the payee is alive.
- **Interest Income**: We will hold the proceeds until withdrawn by the payee. The payee may withdraw all or part of the proceeds at any time. Any proceeds not withdrawn will be paid at the death of the payee. Interest on any unpaid balance will be accumulated or paid annually, semi-annually, quarterly or monthly, as selected.
- **Income of Fixed Amount**: We will pay the proceeds in installments of a selected amount until all of the proceeds and interest are fully paid.
- **Annuity**: We will apply the proceeds as a single premium to purchase an annuity payable to one or two payees. The annuity payments will continue while the payee is living, or if an annuity for two payees is selected, payments will continue while either is still living. The amount of each annuity payment will not be less than the amount of the payment which proceeds of this policy would otherwise provide based on the annuity rates we are using on the date the proceeds of this policy become payable. If at any age the amount of the equal installment payments is the same for more than one period certain, payment will be made as if the longer period certain was chosen.

Any other reasonable method of settlement may be arranged subject to our agreement.

If you prefer a settlement in accordance with any of the installment options as indicated above, please state which option. If you do not indicate your preference, a Lump-Sum Payment will be issued:

_____

E. Request for Taxpayer Identification Number and Certification

☐ Check this box **ONLY** if you are **NOT** a U. S. Citizen or resident or otherwise not subject to U.S. taxation. **If this box is checked, STOP HERE and complete an IRS W-8BEN form.**

Social Security Number: _____ - ____ - _____
OR
Employer, Trust, or Estate Tax Identification Number: _____ - _____

Under the penalties of perjury, I certify that:
The number shown above is the correct taxpayer identification number for the individual/entity claiming the proceeds (or I am waiting for a number to be issued) AND (please check one of the following in order to receive the death benefit proceeds):

☐ **I am NOT subject to Backup Tax Withholding because:**

a) I am exempt from Backup Tax Withholding, or
b) I have not been notified by the IRS that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or
c) The IRS has notified me that I am no longer subject to Backup Tax Withholding. (Does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends).

☐ **I am subject to Backup Tax Withholding.**

Also, please check the box below if applicable:

☐ **I am a U.S. person (including a U.S. resident alien).**

(continued on next page)

(Section E. continued)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed & Dated at: _____ this _____ day of _____, _____.
City, State Day Month Year

Signature of Claimant, Trustee, Executor or Signing Officer

X_____

F. Claimant's Signature

Any person who knowingly and with intent, defrauds or deceives an insurance company by submitting or filing a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, may be guilty of insurance fraud, which may be a crime and may be subject to criminal and/or civil penalties.

By signing below, I attest that the information in this Claimant's Statement is complete and true to the best of my knowledge, and that I have read and understand the Fraud Warning Notice set out on Form W11D047 for my state of residence, if any.

Signed & Dated at: _____ this _____ day of _____, _____.
City. State Day Month Year

Signature of Claimant, Trustee, Executor or Signing Officer

X_____

Claimant's Printed Name

_____

Signature of Witness

X_____

Witness' Printed Name

_____

For contracts issued in and residents of Illinois only:
A valid claim will include interest due and payable from the date of death at a rate of 10% if we do not pay the claim within 31 days from the latest of 1) the date that we receive proof of death, 2) the date we receive sufficient information to determine our liability and the appropriate beneficiary(ies) entitled to the proceeds; or 3) the date that any legal impediments are resolved.

For Vermont contracts only:
Pursuant to Vermont law, interest will accrue on the proceeds from the date of death of the insured to date of payment at the rate of 6.00%.

The Chesapeake Life Insurance Company

Claimant's Statement

In order to process your claim as quickly as possible, we need some information about you and the insured. Please submit the original insurance policy(ies), a certified death certificate that includes the cause and manner of death, and the original Claimant's Statement(s). Only one certified death certificate is needed to process your claim. Each Claimant must submit their own Claimant's Statement. If you need assistance in completing this form, the company or one of its representatives will assist you.

A. Insured's Information

1. Name: Daniel R Parker Date of Death: 10/06/2016
   Other names used by the Insured: N/a
2. Please list all policy/contract numbers with our company on which you are filing a claim:
   n/a N081101931
3. **Please note:** All policies listed above should be submitted with your claim. If policies are not attached, please state why:
   n/a / lost policy
4. Address: [redacted]
   Street Address/P.O. Box City, State and Zip Code
5. Marital Status:
   Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☒ Other ☐ (specify) _____
6. Date of Birth: [redacted] Place of Birth: [redacted]
7. Cause of Death: [redacted]
8. Manner of Death:
   Natural ☒ Homicide ☐ Accident ☐ Suicide ☐ Other (specify) _____
9. Occupation: retired Veteran (Sgt.) Date Last Worked: _____
10. Employer Name: _____ Employer Phone Number: _____
11. Employer Address: _____

B. Claimant's Information

1. Name: Connie R. Skenandore Relationship to Insured: sister
2. Date of Birth: [redacted] Sex: Male ☐ Female ☒
3. In what capacity are you claiming the death benefit? **Please check the box that applies to you.**
   Named Beneficiary ☒ Executor/Administrator ☐ Legal Guardian ☐ Trustee ☐ Other ☐ (specify)
   _____
   Mailing Address: [redacted]
   Street Address/P.O. Box City, State and Zip Code
4. Phone Numbers: (WK) _____ (HM) [redacted] (CELL) [redacted]
5. Email Address: [redacted]
6. Please indicate preferred method of communication: Mail ☐ Phone ☒ Email ☐
7. Citizenship, if not U.S.A.: _____

C. Information about other insurance

List any additional life insurance on the life of the Insured.
physical Mutual, Mutual Omaha Group, Ameritas

D. Settlement Options

Installment Options Settlement Descriptions

All or part of the proceeds of the policy may be paid under any one or a combination of the following options. Please review Insured's policy for the specific options available to you.

- **Income for Fixed Period:** Payments, determined from the table provided in the policy, guaranteed for the number of years chosen.

(continued on next page)

EXHIBIT tabbies G

0000824.0001687

(Section D. continued)

- **Life Income**: Payments, determined from the table in the policy, for the Option elected, based on the payee's sex and age nearest birthday on the date the first payment becomes due. Life income options available are (1) payments only while the payee is alive; or (2) payments guaranteed for 10 years; then continuing while the payee is alive.
- **Interest Income**: We will hold the proceeds until withdrawn by the payee. The payee may withdraw all or part of the proceeds at any time. Any proceeds not withdrawn will be paid at the death of the payee. Interest on any unpaid balance will be accumulated or paid annually, semi-annually, quarterly or monthly, as selected.
- **Income of Fixed Amount**: We will pay the proceeds in installments of a selected amount until all of the proceeds and interest are fully paid.
- **Annuity**: We will apply the proceeds as a single premium to purchase an annuity payable to one or two payees. The annuity payments will continue while the payee is living, or if an annuity for two payees is selected, payments will continue while either is still living. The amount of each annuity payment will not be less than the amount of the payment which proceeds of this policy would otherwise provide based on the annuity rates we are using on the date the proceeds of this policy become payable. If at any age the amount of the equal installment payments is the same for more than one period certain, payment will be made as if the longer period certain was chosen.

Any other reasonable method of settlement may be arranged subject to our agreement.

If you prefer a settlement in accordance with any of the installment options as indicated above, please state which option. If you do not indicate your preference, a Lump-Sum Payment will be issued:

____

E. Request for Taxpayer Identification Number and Certification

☐ Check this box ONLY if you are NOT a U. S. Citizen or resident or otherwise not subject to U.S. taxation. **If this box is checked, STOP HERE and complete an IRS W-8BEN form.**

Social Security Number: [redacted]
OR
Employer, Trust, or Estate Tax Identification Number: _______-_________

Under the penalties of perjury, I certify that:
The number shown above is the correct taxpayer identification number for the individual/entity claiming the proceeds (or I am waiting for a number to be issued) AND (please check one of the following in order to receive the death benefit proceeds):

☒ **I am NOT subject to Backup Tax Withholding because:**

a) I am exempt from Backup Tax Withholding, or
b) I have not been notified by the IRS that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or
c) The IRS has notified me that I am no longer subject to Backup Tax Withholding. (Does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends).

☐ **I am subject to Backup Tax Withholding.**

Also, please check the box below if applicable:

☐ **I am a U.S. person (including a U.S. resident alien).**

(continued on next page)

(Section E. continued)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed & Dated at: Green Bay WI (City, State) this 9th (Day) day of 02 (Month), 2017 (Year).

Signature of Claimant, Trustee, Executor or Signing Officer

X Connie Skenandore

F. Claimant's Signature

Any person who knowingly and with intent, defrauds or deceives an insurance company by submitting or filing a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, may be guilty of insurance fraud, which may be a crime and may be subject to criminal and/or civil penalties.

By signing below, I attest that the information in this Claimant's Statement is complete and true to the best of my knowledge, and that I have read and understand the Fraud Warning Notice set out on Form W11D047 for my state of residence, if any.

Signed & Dated at Green Bay, WI (City, State) this 9th (Day) day of 02 (Month), 2017 (Year).

Signature of Claimant, Trustee, Executor or Signing Officer

X Connie Skenandore

Claimant's Printed Name

Connie Skenandore

Signature of Witness

X

Witness' Printed Name

Tami Hill

For contracts issued in and residents of Illinois only:
A valid claim will include interest due and payable from the date of death at a rate of 10% if we do not pay the claim within 31 days from the latest of 1) the date that we receive proof of death, 2) the date we receive sufficient information to determine our liability and the appropriate beneficiary(ies) entitled to the proceeds; or 3) the date that any legal impediments are resolved.

For Vermont contracts only:
Pursuant to Vermont law, interest will accrue on the proceeds from the date of death of the insured to date of payment at the rate of 6.00%.