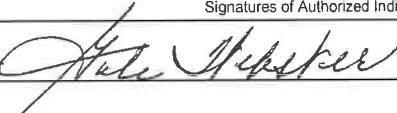
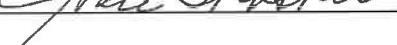


Account Holder Names: GALE WEBSTER		ACCOUNT NUMBER: 210863254	WSFS Fresh Start Checking
MULTI-PURPOSE		ACCOUNT PURPOSE: Consumer	ACCOUNT TYPE: Personal
Mailing Address: 28 Wenark Drive, #6, Newark, DE, 19711		OWNERSHIP TYPE: Single Owner	<i>Comb + TT</i>
Home Phone: (302) 213-4004	Work Phone:	DATE OPENED: 12/24/2014	DATE REVISED:
Number of Signatures Required: 1	CIF Number: 00000625984	VERIFIED BY:	OPENED BY: Alex Kaplan
Special Instructions: Trolley Signatures of Authorized Individuals. This Agreement is subject to all terms below.			
1x Name Gale Webster 	2x Name	3x Name 	4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

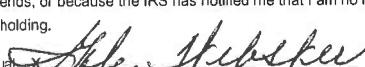
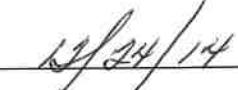
TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 250115182

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual: Date: 

For instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Gale Webster

SSN: 250115182

Street: 28 Wenark Drive, #6 Newark DE 19711

Mailing:

Home Phone #: (302) 213-4004

Work Phone #:

Employer:

Occupation:

DOB: 11/14/1958

Birth Place:

DL/ID#: 1208412

MMN:

Signer #2:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #3:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #4:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #6:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #7:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #8:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #9:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

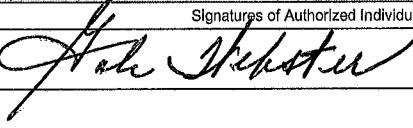
Signer #10:	SSN:
-------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address:	SSN:
-------------------------------------	------

Account Holder Names: GALE WEBSTER		ACCOUNT NUMBER: 468746532	WSFS Core Savings
MULTI PURPOSE		ACCOUNT PURPOSE: Consumer	ACCOUNT TYPE: Personal
Mailing Address: 28 Wenark Drive, #6, Newark, DE, 19711		OWNERSHIP TYPE: Single Owner	DATE OPENED: 12/24/2014
Home Phone: (302) 213-4004	Work Phone:	DATE REVISED:	
Number of Signatures Required: 1	CIF Number: 00000625984	VERIFIED BY:	OPENED BY: Alex Kaplan
Special Instructions		Trolley Signatures of Authorized Individuals: This Agreement is subject to all terms below.	

1x Name Gale Webster		2x Name
3x Name		4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document. The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

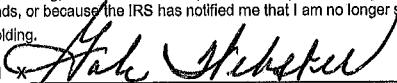
TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 250115182

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual Date: 11/24/14

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

MMN = Mother's Maiden Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

Signer #1: Gale Webster	SSN: 250115182
-------------------------	----------------

Street: 28 Wenark Drive, #6 Newark DE 19711

Mailing:

Home Phone #: (302) 213-4004

Work Phone #:

Employer:

Occupation:

DOB: 11/14/1958

Birth Place:

DL/ID#: 1208412

MMN:

Signer #2:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #3:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #4:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

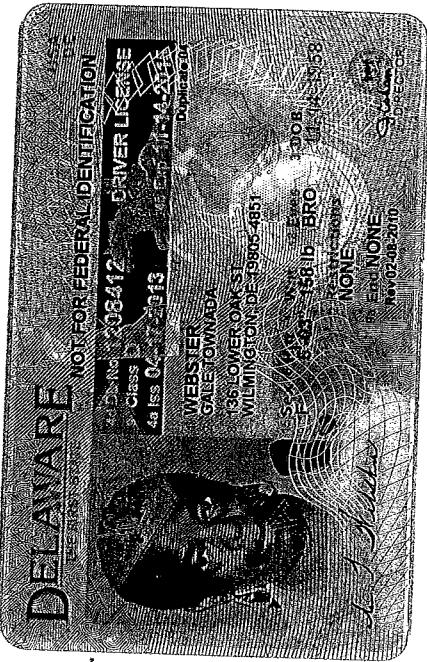
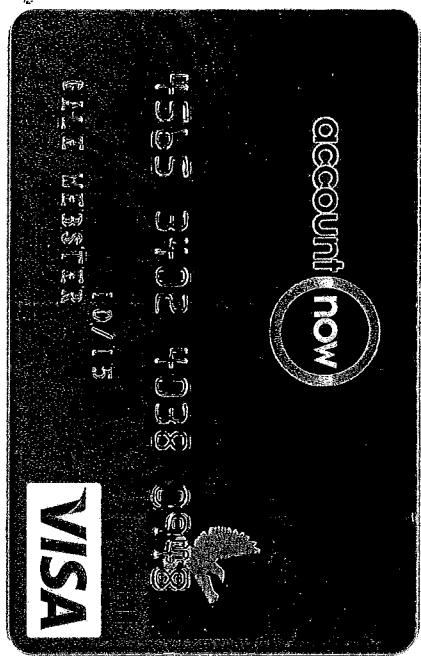
Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #6:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #7:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #8:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #9:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #10:	SSN:
Beneficiary/Payee Name and Address:	SSN:




[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Gale Webster
28 Wenark Drive, #6
Newark, DE 19711

SSN/TIN: 250-11-5182
DOB: 11/14/1958

DL#: 1208412
DL State: DE

Home Phone: (302)213-4004

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: DECLINE

Recommended Actions: PROVIDE ADVERSE ACTION FORM
CHECK BOX FOR CHEXSYSTEMS

Qualifile® Detail

		Code	Text
Qualifile Score:	0518	Reasons:	TIME SINCE NON-DDA INQUIRY ACTIVITY
		AG	CURRENT ADDRESS CHANGE HISTORY
		AK	NO EVIDENCE OF ASSET OWNERSHIP
		AX	DDA CLOSURE PAYMENT HISTORY
		AP	

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1972 IN SC SSN:
DL Format: VALID DRIVERS LICENSE FORMAT

CheXsystems® History

Total Closures:	1	Total Purchased Debt:	0
Disputed:	0	Disputed:	0
Paid:	0	Paid:	0
Unpaid:	1	Unpaid:	0
Partially Paid:	0	Partially Paid:	0
Sold:	0	Sold:	0

Retail: NOTE * THERE IS NO RETAIL INDICATOR

Closure Details

Total Number of Closures: 1

Date Reported	Reported By	Charge-Off Amt.	Collections
12/07/2011	CITIZENS BANK	\$1,967.19	No

Closure 1 of 1

Date Reported: 12/07/2011
Charge-off Amt: \$1,967.19
SSN/ITIN: 250-11-5182
Settlement Date:

Closure Reason(s)	Category
1 ACCOUNT ABUSE	ACCOUNT ABUSE

REPORTED INFORMATION
SSN/TIN: 250-11-5182
GALE T SADDLER
136 LOWER OAK ST

ACCOUNT CLOSED BY
CITIZENS BANK
REPORTING CODE
1 CITIZENS DRIVE

WILMINGTON, DE 19805-4851

RIVERSIDE, RI 02915

COLLECTIONS INFORMATION**Purchased Debt Details**

No Purchased Debt Found

Inquiry Details

No Previous Inquiries Found

Inquiry ID

681190485

Reference Detail

OFAC OID#: 1656334078
Debit Bureau Reference#: 14LO39678224
Transaction Tracking ID: 1419440478206:73342:UXAP304P_Z2:
Location ID: OH

[Back To Top](#)**IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES**

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

[Data Practices](#) [Privacy Policy](#) [Terms of Use](#)

[Privacy Statement](#) [Legal Notices](#)
2014 [Harland Clarke](#) All Rights Reserved.



Attorneys at Law

WILMINGTON
GEORGETOWN
MIDDLETOWN
NEW YORK

Karen Kochanski

PARALEGAL
P 302.571.4749
F 302.576.3375
KKOCHANSKI@YCST.COM

December 24, 2014

Ms. Gale Webster
28 Wenark Drive, #6
Newark, DE 19711

Re: Gale Webster v. Regal Heights

Dear Ms. Webster:

Enclosed is this firm's Escrow Account check in the amount of \$11,135.83, representing the net proceeds of your recent settlement for total disability. This does NOT conclude your workers' compensation case and the carrier will remain responsible for all future benefits and reasonable and necessary medical treatment.

Very truly yours,

A handwritten signature in cursive ink that appears to read "Karen".

Karen Kochanski
Paralegal to Timothy E. Lengkeek

KK:kk
Enclosure
FC: corr

01:16449356.1



Certificate of Deposit Rollover Form

Customer Information

CD Account Number:

Customer Name:

Address:

City, State and Zip:

0465048494

Janet Cross

411 Canoe Club RD

Newark, de, 19701

- 221-18-7075

Current Certificate of Deposit Details

Last Maturity Date:

12/15/2012

Term:

24

Date Opened:

12/15/2012

Interest Rate:

.150

Certificate of Deposit (CD) Rollover Details

New Monthly Term:

24

New Maturity Date:

12/24/2016

New Interest Rate:

.499

New APY:

.50

New Interest Frequency Period:

Maturity

Interest Payment Option:

No Changes

Transfer Account (if appl.):

Additional Comments:

Important

Day of Maturity = Day of CD Opening, Not Day of CD Rollover

VERIFIED
BRENDA HALLSTEAP

Required Information and Signatures

12/24/2014

Date of Rollover:

Ciara Roberts

Associate Name:

Janet T. Cross

Customer Name:

Select Location

Branch Name:

308

Unit Number:

Associate Signature:

Customer Signature:



Certificate of Deposit Rollover Form

Customer Information

CD Account Number:

0465048478

Customer Name:

Janet Cross

Address:

411 Canoe Club Rd

City, State and Zip:

Newark, de, 19702

Current Certificate of Deposit Details

Last Maturity Date:

12/15/2012

Term:

24

Date Opened:

12/15/2012

Interest Rate:

.150

Certificate of Deposit (CD) Rollover Details

New Monthly Term:

36

New Maturity Date:

12/24/2017

New Interest Rate:

.996

New APY:

1.00

New Interest Frequency Period:

Maturity

Interest Payment Option:

No Changes

Transfer Account (if appl.):

Additional Comments:

Important

Day of Maturity = Day of CD Opening, Not Day of CD Rollover

Required Information and Signatures

12/24/2014

Date of Rollover:

Ciara Roberts

Associate Name:

Janet T. Cross

Customer Name:

Select Location

Branch Name:

Amelia

Associate Signature:

Janet T. Cross

Customer Signature:

308

Unit Number:



Certificate of Deposit Rollover Form

Customer Information

CD Account Number:

0465048486

Customer Name:

Janet Cross

Address:

411 Canoe Club RD

City, State and Zip:

Newark, de, 19702

Current Certificate of Deposit Details

Last Maturity Date:

12/15/2012

Term:

24

Date Opened:

12/15/2012

Interest Rate:

.150

Certificate of Deposit (CD) Rollover Details

New Monthly Term:

36

New Maturity Date:

12/24/2017

New Interest Rate:

.996

New APY:

1.00

New Interest Frequency Period:

Maturity

Interest Payment Option:

No Changes

Transfer Account (if appl.):

Additional Comments:

Important

Day of Maturity = Day of CD Opening, Not Day of CD Rollover

Required Information and Signatures

12/24/2014

Date of Rollover:

ciara roberts

Associate Name:

Janet T Cross

Customer Name:

Select Location

Branch Name:



Associate Signature:



Customer Signature:

308

Unit Number:



Certificate of Deposit Rollover Form

Customer Information

CD Account Number:

0495863862

Customer Name:

Janet Cross

Address:

411 Canoe Club RD

City, State and Zip:

Newark, De, 19702

Current Certificate of Deposit Details

Last Maturity Date:

10/14/2014

Term:

24

Date Opened:

10/14/2012

Interest Rate:

.400

Not at maturity

Certificate of Deposit (CD) Rollover Details

New Monthly Term:

36

New Maturity Date:

12/24/2017

New Interest Rate:

.996

New APY:

1.00

New Interest Frequency Period:

Maturity

Interest Payment Option:

No Changes

Transfer Account (if appl.):

Additional Comments:

Important

Day of Maturity = Day of CD Opening, Not Day of CD Rollover

Required Information and Signatures

12/24/2014

Date of Rollover:

Ciara Roberts

Associate Name:

Janet T Cross

Customer Name:

Select Location

Branch Name:

Alia M

Associate Signature:

Janet T Cross

Customer Signature:

308

Unit Number:



Certificate of Deposit Rollover Form

Customer Information

CD Account Number:

0465048502

Customer Name:

Janet Cross

Address:

411 Canoe Club RD

City, State and Zip:

Newark, de, 19701

Current Certificate of Deposit Details

Last Maturity Date:

12/15/2012

Term:

24

Date Opened:

12/15/2012

Interest Rate:

.150

Certificate of Deposit (CD) Rollover Details

New Monthly Term:

24

New Maturity Date:

12/24/2016

New Interest Rate:

.499

New APY:

.50

New Interest Frequency Period:

Maturity

Interest Payment Option:

No Changes

Transfer Account (if appl.):

Additional Comments:

VERIFIED
BRENDA HALLSTEAD

Important

Day of Maturity = Day of CD Opening, Not Day of CD Rollover

Required Information and Signatures

12/24/2014

Date of Rollover:

ciara roberts

Associate Name:

Janet T. Cross

Customer Name:

Select Location

308

Branch Name:

Unit Number:

Associate Signature:

Janet T. Cross

Customer Signature:

Account Holder Names: JAMES GROFF OR JUDITH A GROFF	ACCOUNT NUMBER: 467647111	WSFS Personal CD
Mailing Address: 622 LANGWATER DR, NEWARK, DE, 19711-2437	ACCOUNT PURPOSE: Consumer	ACCOUNT TYPE: Personal
Home Phone: (302) 239-9834	OWNERSHIP TYPE: Joint Owners	DATE OPENED: 12/24/2014
Number of Signatures Required: 1	VERIFIED BY:	DATE REVISED: OPENED BY: Kelly Bogush
Special Instructions:	Pike Creek	
Signatures of Authorized Individuals. This Agreement is subject to all terms below.		
1x Name JAMES GROFF	2x Name JUDITH A GROFF	
3x Name	4x Name	

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 222-26-7562

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual X

Date: _____

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: JAMES GROFF

SSN: 222-26-7562

Street: 622 LANGWATER DR NEWARK DE 197112437

Mailing: 622 LANGWATER DR, NEWARK, DE, 19711-2437

Home Phone #: (302) 239-9834

Work Phone #:

Employer:

Occupation:

DOB: 8/18/1943

Birth Place:

DL/ID#: 431623

MMN:

Signer #2: JUDITH A GROFF

SSN: 222-28-1566

Street: 622 LANGWATER DR NEWARK DE 197112437

Mailing:

Home Phone #: (302) 239-9834

Work Phone #: (302) 886-5486

Employer:

Occupation:

DOB: 6/29/1945

Birth Place:

DL/ID#: 478489

MMN:

Signer #3:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #4:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

DEC 26 2014

#298

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5x Name	6x Name
7x Name	8x Name
9x Name	10x Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
-------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #6:	SSN:
-------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #7:	SSN:
-------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #8:	SSN:
-------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #9:	SSN:
-------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #10:	SSN:
--------------------	-------------

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Beneficiary/Payee Name and Address:	SSN:
--	-------------

CONFIRMATION OF TIME DEPOSIT

FINANCIAL INSTITUTION: WSFS Bank, 500 Delaware Ave, Wilmington, DE 19801-		NUMBER:	
ACCOUNT NAME(S): JAMES GROFF OR JUDITH A GROFF			
OWNERSHIP TYPE: Joint Owners SSN/TIN: 222-26-7662			
ACCOUNT NO. 467647111	ISSUE DATE 12/24/2014	DEPOSIT AMOUNT	TERM 36 MATURITY DATE 12/24/2017
RATE INFORMATION			
<p>This account is an interest bearing account. The interest rate on the account is 1.243 with an annual percentage yield of 1.25%.</p> <p><input checked="" type="checkbox"/> The interest rate and annual percentage yield will not change for the term of your account.</p> <p><input type="checkbox"/> The interest rate and annual percentage yield may change: (select one that applies):</p> <ul style="list-style-type: none"> <input type="checkbox"/> At our discretion, we may change the interest rate on the account. <input type="checkbox"/> At your discretion, you may change the interest rate on the account. <input type="checkbox"/> The interest rate and annual percentage yield will not change for at least thirty (30) calendar days. We agree to give you thirty (30) days' advance written notice prior to decreasing the rate. <input type="checkbox"/> The interest rate on the account is based on _____ (index) <input type="checkbox"/> PLUS <input type="checkbox"/> MINUS a margin of: _____ (frequency) <input type="checkbox"/> The interest rate on your account may change <input type="checkbox"/> The interest rate will never be <input type="checkbox"/> less than _____ <input type="checkbox"/> more than _____. <input type="checkbox"/> The interest rate will never <input type="checkbox"/> increase by more than _____ <input type="checkbox"/> decrease by more than _____ each rate change. <input type="checkbox"/> The interest rate will never <input type="checkbox"/> drop more than _____ below <input type="checkbox"/> exceed _____ above the interest rate initially disclosed to you. <p>Interest begins to accrue (select one that applies):</p> <ul style="list-style-type: none"> <input type="checkbox"/> on the business day you deposit noncash items (for example, checks). <input checked="" type="checkbox"/> no later than the business day we receive credit for the deposit of noncash items (for example, checks). <p>Interest <input type="checkbox"/> will not be <input checked="" type="checkbox"/> will be compounded Actual/365 days.</p> <p>Interest on your account will be credited <u>At Maturity</u> by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Adding Interest to the Principal <input type="checkbox"/> Depositing interest to account no.: _____ <input type="checkbox"/> Mailing a check to: _____ <input type="checkbox"/> If the account is closed before interest is credited, you will not receive the accrued interest. 			
BALANCE INFORMATION			
<p>We use the (select one that applies):</p> <p><input type="checkbox"/> daily balance method to calculate interest on the account. This method applies a daily periodic rate to the principal in the account each day.</p> <p><input type="checkbox"/> average-daily-balance method to calculate interest on the account. This method applies a periodic rate to the average daily balance in the account for the period. The average daily balance is calculated by adding the principal in the account for each day of the period and dividing that figure by the number of days in the period.</p> <p><input checked="" type="checkbox"/> other: We use the daily balance method to calculate interest on your account. This method applies a daily periodic rate to the principal in the account each day. The daily balance that we use when calculating interest is the collected balance. That means we only include those funds for which we have actually received account when we determine the balance on which interest is paid.</p> <p>We will use an interest accrual basis of (select one that applies):</p> <p><input checked="" type="checkbox"/> 365 for each day in the year. <input type="checkbox"/> 365 (or 366 in a leap year) for each day in the year. <input type="checkbox"/> 360 for each day in the year.</p>			
<p>You must maintain a minimum (select one that applies):</p> <p><input type="checkbox"/> balance of 0.00 in the account each day to obtain the disclosed annual percentage yield.</p> <p><input type="checkbox"/> average daily balance of 0.00 in the account each day to obtain the disclosed annual percentage yield. The average daily balance is calculated by adding the principal in the account for each day of the period and dividing that figure by the number of days in the period.</p>			
LIMITATIONS			
<p><input checked="" type="checkbox"/> You must deposit 2,500.00 to open this account.</p> <p><input type="checkbox"/> You may not make additional deposits into this account.</p> <p><input type="checkbox"/> You may not deposit more than 0.00 to this account.</p> <p><input checked="" type="checkbox"/> You may not make withdrawals from your account until the maturity date.</p> <p><input checked="" type="checkbox"/> Deposit limitations are as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> You may not make deposits into your account until the maturity date. <input checked="" type="checkbox"/> Withdrawal limitations are as follows: <input type="checkbox"/> You may not make withdrawals from your account until the maturity date. 			
TIME ACCOUNT INFORMATION			
<p>If you withdraw any of the principal or interest before the maturity date, we may impose a penalty of: 1) 3 months interest for CDs up to 6 months, 2) 6 months interest for _____.</p> <p>We will use the rate in effect on the date of (select one that applies):</p> <p><input type="checkbox"/> the account was opened.</p> <p><input type="checkbox"/> date of withdrawal.</p> <p><input type="checkbox"/> This account requires the distribution of interest and does not allow interest to remain in the account. (Interim APY Rule applies)</p> <p><input checked="" type="checkbox"/> The annual percentage yield assumes interest will remain on deposit until maturity. A withdrawal will reduce earnings.</p> <p><input checked="" type="checkbox"/> Automatic Renewal. Grace Period: 10 Calendar Days</p> <p><input checked="" type="checkbox"/> If you do not withdraw the funds, each renewal term will be for an identical period of time as the original term.</p> <p><input type="checkbox"/> The renewal term is described as follows:</p> <p><input type="checkbox"/> Single Maturity</p> <p>If you do not renew the account, we will do the following with your deposit:</p> <p><input type="checkbox"/> We reserve the right to redeem the account under the following circumstances:</p>			
FEE INFORMATION			
<p>Account Fees/Service Charge, balance to avoid service charge and how balance is determined:</p> <p>The following fees may be assessed against your account: Please refer to our "Deposit Products Fee Schedule" for other fees applicable to your account. We may change these fees at any time.</p>			
BONUS INFORMATION			
<p><input type="checkbox"/> You will receive _____ as a bonus. To obtain the bonus you must maintain:</p> <p>For:</p> <p>SIGNATURE AND TITLE OF AUTHORIZED FINANCIAL INSTITUTION SIGNER</p>			

NONTRANSFERABLE

NONNEGOTIABLE

TIME DEPOSIT AGREEMENT

PRODUCT NAME: WSFS Personal CD

We appreciate your decision to open a time deposit account with us. This Agreement sets forth certain conditions, rates, and rules that are specific to your Account. Each signer acknowledges that the Account Holder named has placed on deposit with the Financial Institution the Deposit Amount indicated, and has agreed to keep the funds on deposit until the Maturity Date. As used in this Agreement, the words "you", "your" or "yours" mean the Account Holder(s), the word "Account" means this Time Deposit Account and the word "Agreement" means this Time Deposit Agreement, and the words "we", "us" and "our" mean the Financial Institution. This Account is effective as of the Issue Date and is valid as of the date we receive credit for noncash items (such as checks drawn on other financial institutions) deposited to open the Account. Deposits of foreign currency will be converted to U.S. funds as of the date of deposit and will be reflected as such on our records.

INTEREST RATE. The Interest rate is the annual rate of interest paid on the Account which does not reflect compounding ("Interest Rate"), and is based upon the Interest accrual basis described above.

AUTOMATIC RENEWAL POLICY. If the Account will automatically renew as described above, the principal amount and all paid earned interest that has not been withdrawn will automatically renew on each Maturity Date for the term described above in the Time Account Information section. If the deposit term causes the Maturity Date to fall on Saturday, Sunday, or a holiday, the Maturity Date will be adjusted to the next business day. Interest on renewed accounts will be calculated at the interest rate then in effect for time deposits of that Deposit Amount and term. If you wish to withdraw funds from your Account, you must notify us during the grace period after the Maturity Date.

EARLY WITHDRAWAL PENALTY. You have agreed to keep the funds on deposit until the Maturity Date of your Account. Any withdrawal of all or part of the funds from your Account prior to maturity may result in an early withdrawal penalty. We will consider requests for early withdrawal and, if granted, the penalty as specified above will apply.

Minimum Required Penalty. If you withdraw money within six (6) days after the date of deposit, the Minimum Required Penalty is seven (7) days' simple interest on the withdrawn funds. If partial early withdrawal(s) are permitted, we are required to impose the Minimum Required Penalty on the amount(s) withdrawn within six (6) days after each partial withdrawal. The early withdrawal penalty may be more than the Minimum Required Penalty. You pay the early withdrawal penalty by forfeiting part of the accrued interest on the Account. If your Account has not earned enough interest, or if the interest has been paid, we take the difference from the principal amount of your Account.

Exceptions. We may let you withdraw money from your Account before the Maturity Date without an early withdrawal penalty: (1) when one or more of you dies or is determined legally incompetent by a court or other administrative body of competent jurisdiction; or (2) when the Account is an Individual Retirement Account (IRA) established in accordance with 26 USC 408 and the money is paid within seven (7) days after the Account is opened; or (3) when the Account is a Keogh Plan (Keogh), if you forfeit at least the interest earned on the withdrawn funds; or (4) if the Account is an IRA or a Keogh Plan established pursuant to 26 USC 408 or 26 USC 401, when you reach age 59 1/2 or become disabled; or (5) within an applicable grace period (if any).

RIGHT OF SETOFF. Subject to applicable law, we may exercise our right of setoff or security interest against any and all of your Accounts (except IRA, Keogh plan and Trust Accounts) without notice, for any liability or debt of any of you, whether joint or individual, whether direct or contingent, whether now or hereafter existing, and whether arising from overdrafts, endorsements, guarantees, loans, attachments, garnishments, levies, attorneys' fees, or other obligations. If the Account is a joint or multiple-party account, each joint or multiple-party account holder authorizes us to exercise our right of setoff against any and all Accounts of each Account Holder.

OTHER ACCOUNT RULES. The following rules also apply to the Account.

Surrender of Instrument. We may require you to endorse and surrender this Agreement to us when you withdraw funds, transfer or close your Account. If you lose this Agreement, you agree to sign any affidavit of lost instrument, or other Agreement we may require, and agree to hold us harmless from liability, prior to our honoring your withdrawal or request.

Death of Account Holder. Each Account Holder agrees to notify us immediately upon the death of any other Account Holder. You agree that we may hold the funds in your Account until we have received all required documentation and instructions.

Indemnity. If you ask us to follow instructions that we believe might expose us to any claim, liability or damages, we may refuse to follow your instructions or may require a bond or other protection, including your agreement to indemnify us.

Pledge. You agree not to pledge your Account without our prior consent. You may not withdraw funds from your Account until all obligations secured by your Account are satisfied.

Account Holder Names: ESTATE OF ANNE BAGROWSKI GEORGE BAGROWSKI EXEC WITH PURPOSES		ACCOUNT NUMBER: 210788279 WSFS Core Checking
Mailing Address: 24 N. JERMAN LANE, CAMDEN, DE, 19934		ACCOUNT PURPOSE: Consumer
Home Phone: (302) 697-3722	Work Phone:	ACCOUNT TYPE: Personal
Number of Signatures Required: 1	CIF Number: 00000625898	OWNERSHIP TYPE: Estate
Special Instructions:		DATE OPENED: 12/22/2014
		DATE REVISED:
		VERIFIED BY: OPENED BY: Shreyas Shah
CAMDEN		

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x ESTATE OF ANNE BAGROWSKI Name Anne Bagrowski <i>George J. Bagrowski</i>	2x Name George Bagrowski <i>George J. Bagrowski</i>
3x Name	4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING**Reporting SSN/TIN: 476694687**

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

- I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.
 I am subject to backup withholding.

Signature of Authorized Individual X *George J. Bagrowski*

Date: _____

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Anne Bagrowski**SSN: 476694687**

Street: 24 N. JERMAN LANE CAMDEN DE 19934

Mailing:

Home Phone #: (302) 697-3722

Work Phone #:

Employer:

Occupation:

DOB: 7/22/1907

Birth Place:

DL/ID#:

MMN:

Signer #2: George Bagrowski**SSN: 216367202**

Street: 24 N JERMAN LN CAMDEN WYOMING DE 199344542

Mailing:

Home Phone #: (302) 697-3722

Work Phone #: (302) 697-3722

Employer:

Occupation:

DOB: 8/18/1939

Birth Place:

DL/ID#: 1525218

MMN: OWSEANIECHI

Signer #3:**SSN:**

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #4:**SSN:**

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

*BRENDA HALLS**DEC 26 2014**#298*

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5x Name	6x Name
7x Name	8x Name
9x Name	10x Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
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Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

Signer #6:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

Signer #7:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

Signer #8:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

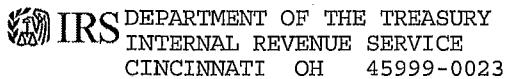
Signer #9:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

Signer #10:	SSN:
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Street:
Mailing:
Home Phone #: Work Phone #:
Employer:
DOB:
DL/ID#:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address:	SSN:
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Date of this notice: 12-22-2014

Employer Identification Number:
47-6694687

Form: SS-4

Number of this notice: CP 575 B

ANNE BAGROWSKI ESTATE
GEORGE J BAGROWSKI PER REP
24 N JERMAN LN
CAMDEN, DE 19934

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 47-6694687. This EIN will identify your estate or trust. If you are not the applicant, please contact the individual who is handling the estate or trust for you. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 1041

04/15/2015

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

(IRS USE ONLY) 575B

12-22-2014 BAGR B 9999999999 SS-4

IMPORTANT REMINDERS:

- * Keep a copy of this notice in your permanent records. This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you. You may give a copy of this document to anyone asking for proof of your EIN.
- * Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
- * Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is BAGR. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Keep this part for your records.

CP 575 B (Rev. 7-2007)

Return this part with any correspondence
so we may identify your account. Please
correct any errors in your name or address.

CP 575 B

9999999999

Your Telephone Number Best Time to Call DATE OF THIS NOTICE: 12-22-2014
() - EMPLOYER IDENTIFICATION NUMBER: 47-6694687

FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023
██

ANNE BAGROWSKI ESTATE
GEORGE J BAGROWSKI PER REP
24 N JERMAN LN
CAMDEN, DE 19934


[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Anne Bagrowski
 24 N. JERMAN-LANE
 CAMDEN, DE 19934

SSN/TIN: 476-69-4687
 DOB: 07/22/1907

Home Phone: (302)697-3722

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0629	Reasons:	Code	Text
			DK	ASSET OWNERSHIP HISTORY
			DI	NO EVIDENCE OF PROPERTY OWNERSHIP
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY
			DC	TIME AT CURRENT ADDRESS UNKNOWN

Non FCRA**Identification Information**

SSN Validation: SSN AVAILABLE FOR RANDOMIZED ISSUANCE SSN:N

ChexSystems® History

No Closures Found
 No Purchased Debt Found
 No Previous Inquiries Found

Inquiry ID

680910246

Reference Detail

OFAC OID#: 1656044272
 Debit Bureau Reference#: 14LM48421734
 Transaction Tracking ID: 1419276421436:49367:UXAP307P_Z2:
 Location ID: OH

[Back To Top](#)
IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

[Data Practices](#) [Privacy Policy](#) [Terms of Use](#)

CIS

STEP # 1 ---Document Prep

CIS WORK OF DATE:

12, 26, 14
Month Day Year

2012

45

Associate:

WB

OF DOCUMENTS

**count includes separator sheets if
multiple page**

SINGLE PAGE (front only)

MULTIPLE PAGE

Legal Paper documents

Front & Back - double count

TYPE OF DOCUMENT: (Circle One)

Signature Cards

Title Updates

IRA

Business Documentation

Cash Management

Account Closes

Account Analysis

Other

STEP # 2 ---Scanning Process

Scanning Date

11/14/2014
MM DD Year

8:54:41
Time (Hour & Minutes)

Associate:

WB

Scanning Count

(circle)

Does this # Match # of
documents?

Yes or No

if No, Why ?

**re-count if needed*

STEP # 3 ---Previewer Image Quality

Previewer File Count

Does this # match # of Documents?

Yes
Yes
Yes
Yes

No

No

No

View customer's signatures ?

Is the Image blurry

Yes

No

Approve File

Associate

WB

Any Issues with this previewer file, notify
management for 2nd review.

MD	Anne Arundel	Severna Park	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX								
10e. Street and Number 24 Truckhouse Rd		10f. Zip Code 21146	10g. Citizen of What Country? USA								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 6	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Homemaker	14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (14 or 5+) Homemaker	16b. Kind of Business/Industry Own Home								
17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) unk									
19a. Informant's Name/Relationship (Type, Print) George J. Bagrowski Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Chalet West, Millersville, MD 21108									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery	Date March 13, 2008	20c. Location - City or Town, State Baltimore, MD								
21. Signature of Funeral Service Licensee <i>K. Gregory Fink</i> M01148		22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
<table border="0"> <tr> <td>a. ACUTE RENAL FAILURE</td> <td>Approximate Interval Between Onset and Death 1 WEEK</td> </tr> <tr> <td>b. DEHYDRATION</td> <td>1 WEEK</td> </tr> <tr> <td>c. DEMENTIA</td> <td>10 YEARS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>				a. ACUTE RENAL FAILURE	Approximate Interval Between Onset and Death 1 WEEK	b. DEHYDRATION	1 WEEK	c. DEMENTIA	10 YEARS	d.	
a. ACUTE RENAL FAILURE	Approximate Interval Between Onset and Death 1 WEEK										
b. DEHYDRATION	1 WEEK										
c. DEMENTIA	10 YEARS										
d.											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS											
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number DS1104										
29b. Signature and title of certifier <i>Wise Star M.D.</i>	29d. Date signed (Month, Day, Year) MARCH 10 2008										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. USHA VEMULAKONDA											
31. Date filed (Month, Day, Year) MAR 14 2008		32. Registrar's Signature <i>John H. Fink</i>									

FILED

IN THE ORPHANS' COURT FOR
(OR)
BEFORE THE REGISTER OF WILLS FOR

NOV 24 2014
ANNE ARUNDEL, MARYLAND
REGISTER OF WILLS
ANNE ARUNDEL COUNTY, MD

IN THE ESTATE OF:

ANNA BAGROWSKI

ESTATE NO. 85723

FOR:

REGULAR ESTATE
PETITION FOR ADMINISTRATION
Estate value in excess of \$50,000.
(If spouse is sole heir or legatee, \$100,000.)
Values for DOD before October 1, 2012 are
\$30,000 and \$50,000 if spouse is the sole
legatee or heir.
Complete and attach **Schedule A**.

SMALL ESTATE
PETITION FOR ADMINISTRATION
Estate value of \$50,000 or less.
(If spouse is sole heir or legatee, \$100,000.)
Values for DOD before October 1, 2012 are
\$30,000 and \$50,000 if spouse is the sole
legatee or heir.
Complete and attach **Schedule B**.

WILL OF NO ESTATE
Complete items 2 and 8
 LIMITED ORDERS
Complete item 2 and
attach **Schedule C**

NOTE: For the purpose of computing whether an estate qualifies as a small estate, value is determined by the fair market value of property less debts of record secured by the property as of the date of death, to the extent that insurance benefits are not payable to the lien holder or secured party for the secured debt. See Code, Estates and Trusts Article, §5-601 (d).

The Petition of:

GEORGE J BAGROWSKI

24 N JERMAN LN BARCLAY FARMS

CAMDEN, DE 19934

Name

Address

Name

Address

Each of us states:

1. I am (a) at least 18 years of age and either a citizen of the United States or a permanent resident of the United States who is the spouse of the decedent, an ancestor of the decedent, a descendant of the decedent, or a sibling of the decedent or (b) a trust company or any other corporation authorized by law to act as a personal representative.
2. The Decedent, ANNA BAGROWSKI, was
domiciled in ANNE ARUNDEL, State of MARYLAND and died on the 10th day of MARCH,
2008, at GENESIS HEALTH CARE, SEVERNA PARK
(place of death)
3. If the decedent was not domiciled in this county at the time of death, this is the proper office in which to file this petition because: N/A
4. I am entitled to priority of appointment as personal representative of the decedent's estate pursuant to §5-104 of the Estates and Trusts Article, Annotated Code of Maryland because: I AM THE SON AND AM APPOINTED IN THE WILL TO ACT
5. I am mentally competent.
6. I have not been convicted of a serious crime.
7. I am not excluded by other provisions of §5-105 (b) of the Estates and Trusts Article, Annotated Code of Maryland from serving as a personal representative.

8. I have made a diligent search for the decedent's will and to the best of my knowledge:

- none exists; or
 the will dated 12/6/1984 (including codicils, if any, dated _____)

accompanying this petition is the last will and it came into my hands in the following manner:

GIVEN TO THE PERSONAL REPRESENTATIVE FOR SAFEKEEPING

and the names and last known addresses of the witnesses are:

SEE WILL 7439 BALTIMORE-ANNAPOLIS BLVD, GLEN BURNIE, MD 21061

SEE WILL 7439 BALTIMORE-ANNAPOLIS BLVD, GLEN BURNIE, MD 21061

9. Other proceedings, known to petitioner, regarding the decedent or the estate are as follows:

NONE

10. If appointed, I accept the duties of the office of personal representative and consent to personal jurisdiction in any action brought in this State against me as personal representative or arising out of the duties of the office of personal representative.

WHEREFORE, I request appointment as personal representative of the decedent's estate and the following relief as indicated:

- that the will and codicils, if any, be admitted to administrative probate;
 that the will and codicils, if any, be admitted to judicial probate;
 that the will and codicils, if any, be filed only;
 that only a limited order be issued;
 that the following additional relief be granted: AS MAY BE REQUIRED

I solemnly affirm under the penalties of perjury that the contents of the foregoing document are true to the best of my knowledge, information and belief.

Attorney

GEORGE J BAGROWSKI

Date

Address

Petitioner

Date

Petitioner

Date

Telephone Number

Telephone Number (optional)

Faxsimile Number

E-mail Address

FILED

IN THE ORPHANS' COURT FOR
(OR)
BEFORE THE REGISTER OF WILLS FOR

NOV 24 2014

ANNE ARUNDEL MARYLAND
REGISTER OF WILLS
ANNE ARUNDEL COUNTY, MD

IN THE ESTATE OF:
ANNA BAGROWSKI

ESTATE NO. 85723

SCHEDULE - B

Small Estate - Assets and Debts of the Decedent

1. I have made a diligent search to discover all property and debts of the decedent and set forth below are:

- (a) A listing of all real and personal property owned by the decedent, individually or as tenant in common, and of any other property to which the decedent or estate would be entitled, including descriptions, values, and how the values were determined:

MARYLAND UNCLAIMED PROPERTY \$1,592.44. TOTAL ESTATE VALUE \$1.592.44.

- (b) A listing of all creditors and claimants and the amounts claimed, including secured, contingent and disputed claims:

FINK FUNERAL HOME \$ 5,926.75

2. Allowable funeral expenses are \$5,000.00; statutory family allowances are \$0.00; and expenses of administration claimed are \$15.93.

3. Attached is a List of Interested Persons.

4. After the time for filing claims has expired, subject to the statutory order of priorities, and subject to the resolution of disputed claims by the parties or the court, I shall (a) pay all proper claims made pursuant to Code, Estates and Trusts Article, §8-104 in the order of priority set forth in Code, Estates and Trusts Article, §8-105, expenses, and allowances not previously paid; (b) if necessary, sell property of the estate in order to do so; and (c) distribute the remaining assets of the estate in accordance with the will or, if none, with the intestacy laws of this State.

I solemnly affirm under the penalties of perjury that the contents of the foregoing document are true to the best of my knowledge, information and belief.

George J Bagrowski
GEORGE J BAGROWSKI

11/24/14
Date

Attorney

Petitioner

Date

Petitioner

Date

Telephone Number

Telephone Number (optional)

Faxsimile Number

E-mail Address

Account Holder Names: ESTATE OF MARIAN L BLACKWELL BRIAN K BLACKWELL EXEC 221 Charleston Dr Mailing Address: 2520 TIGANI DR, WILMINGTON, DE, 19808-2519		ACCOUNT NUMBER: 210717179 WSFS Core Checking
Home Phone: (302) 994-2621	Work Phone:	ACCOUNT PURPOSE: Consumer
Number of Signatures Required: 1	CIF Number: 00000019040	ACCOUNT TYPE: Personal
Special Instructions:		OWNERSHIP TYPE: Estate
		DATE OPENED: 12/23/2014
		DATE REVISED:
		VERIFIED BY: OPENED BY: Justin Domanski
GREENVILLE		

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x Name Marian L Blackwell	2x Name Brian K Blackwell <i>Brian K Blackwell</i>
3x Name	4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN- 211-20-0747 47-6629214

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual X *Brian K Blackwell*

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Marian L Blackwell	SSN: 211-20-0747
-------------------------------	------------------

Street: 2520 TIGANI DR WILMINGTON DE 198082519

Mailing: 2520 TIGANI DR, WILMINGTON, DE, 19808-2519

Home Phone #: (302) 994-2621

Work Phone #:

Employer:

Occupation:

DOB: 2/8/1930

Birth Place:

DL/ID#: 211200747

MMN:

Signer #2: Brian K Blackwell	SSN: 221468915
------------------------------	----------------

Street: 221 CHARLESTON DR WILMINGTON DE 198084358

Mailing:

Work Phone #: (302) 573-6136

Home Phone #: (302) 354-7767

Occupation:

Employer:

Birth Place:

DOB: 9/16/1956

MMN:

DL/ID#: 716354

SSN:

Signer #3:	SSN:
------------	------

Street:

Work Phone #:

Mailing:

Occupation:

Home Phone #:

Birth Place:

Employer:

MMN:

DOB:

SSN:

DL/ID#:

Signer #4:	SSN:
------------	------

Street:

Work Phone #:

Mailing:

Occupation:

Home Phone #:

Birth Place:

Employer:

MMN:

DOB:

DL/ID#:	SSN:
---------	------

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of court must each sign this signature card. Depositor's Authorization Documents have not been filed.

DEC 26 2014

298

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
-------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Signer #6:	SSN:
-------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Signer #7:	SSN:
-------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Signer #8:	SSN:
-------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Signer #9:	SSN:
-------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Signer #10:	SSN:
--------------------	------

Street:
 Mailing:
 Home Phone #:
 Employer:
 DOB:
 DL/ID#:

Work Phone #:
 Occupation:
 Birth Place:
 MMN:
 SSN:

Beneficiary/Payee Name and Address:	SSN:
--	------



I certify that this is a true and correct copy
Of Short Certificate (name of document)
Given by Brian Blackwell WSFS
And that the same is still in full force and effect

Brian K Blackwell Signature

12/23/14 Date

NEW CASTLE COUNTY, SS.

I, Ciro Poppiti, III, Register of Wills for New Castle County, State of Delaware, do hereby certify that on the 26th day of NOVEMBER, 2014, LETTERS TESTAMENTARY upon the Estate of MARIAN LORRAINE BLACKWELL a.k.a. MARIAN L. BLACKWELL, deceased, were in due form of law granted unto BRIAN KEITH BLACKWELL, who is/are now the Personal Representative(s) upon said estate, to all whose acts, as such, full faith and credit are to be given. I do further certify that the Personal Representative(s) is/are invested with full authority to direct and execute the transfer, assignment, or reissue of any stocks, bonds, documents of title, money in banks, or other securities of any incorporated company, being owned and held by the decedent at the time of his/her death and now constituting part of his/her personal estate. This appointment is still in full force and effect.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal,
this 26th day of NOVEMBER, 2014.

File # 159933

Ciro Poppiti

Register of Wills

NOT VALID WITHOUT IMPRESSED SEAL

CERTIFICATION OF VITAL RECORD

DEATH CERTIFICATION

State of Delaware
Department of Health and Social Services

I certify that this is a true and correct copy
of Death Certificate (name of document)
Given by Brian Blackwell to USFS
and that the same is still in full force and effect.

Signature

Brian K Blackwell Signature

STATE FILE NUMBER:

107-14-006710

Brian K Blackwell

12/23/14

DECEDENT'S INFORMATION:

NAME: *MARIAN L BLACKWELL*

AKA'S: NOT LISTED

SEX: FEMALE

DATE OF DEATH: OCT 26 2014

SOCIAL SECURITY NUMBER: 211-20-0747

DATE OF BIRTH: FEB 08 1930

ARMED FORCES: NO

AGE: 84 YEARS

PLACE OF DEATH INFORMATION:

TYPE: NURSING HOME/LONG TERM CARE FACILITY

FACILITY NAME AND ADDRESS: MILLCROFT NURSING HOME, 19711-3877

DISPOSITION INFORMATION:

METHOD: BURIAL

PLACE: WHITE CHURCH CEMETERY

LOCATION: PENNSYLVANIA

DEMOGRAPHIC INFORMATION:

RESIDENCE: 2520 TIGON DRIVE, WILMINGTON, NEW CASTLE COUNTY, DELAWARE, 19808

PLACE OF BIRTH: PENNSYLVANIA

MARITAL STATUS: WIDOWED (AND NOT REMARRIED)

SURVIVING SPOUSE'S NAME: NOT LISTED

FATHER'S NAME: FRANK PHILLIPS

MOTHER'S NAME PRIOR TO FIRST MARRIAGE: REBA WEBB

INFORMANT'S INFORMATION:

INFORMANT'S NAME: MARK BLACKWELL

RELATIONSHIP: Son

MAILING ADDRESS: 2713 KESWICK COURT, WILMINGTON, DELAWARE, 19808

FUNERAL HOME: DOHERTY FUNERAL HOMES, INC., 1900 DELAWARE AVE, WILMINGTON, NEWCASTLE COUNTY, DELAWARE, 19806

FUNERAL DIRECTOR: JAMES PMULLIN

LICENSE NUMBER: K1-0000529

CAUSE OF DEATH - PART I

GASTROINTESTINAL BLEEDING

DEMENTIA

CHRONIC HEART FAILURE DIASTOLIC

PART II

ME CONTACTED? NO

AUTOPSY PERFORMED? NO

AUTOPSY AVAILABLE?

ACTUAL OR PRESUMED TIME OF DEATH: 09:25 MANNER OF DEATH: NATURAL

INJURY INFORMATION:

DATE OF INJURY:

TIME OF INJURY:

INJURY AT WORK?

PLACE OF INJURY:

LOCATION OF INJURY:

HOW THE INJURY OCCURRED?

CERTIFIER NAME AND TITLE: NANA KUTATELADZE, MD

LICENSE NUMBER: CT-0008503

CERTIFIER ADDRESS: 111 CONTINENTAL DRIVE SUITE 406, NEWARK, NEW CASTLE COUNTY, DELAWARE, 19713

DATE FILED: OCT 30 2014

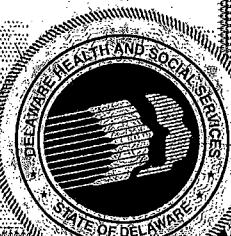
DATE OF ISSUANCE: OCT 31 2014

SPECIAL INSTRUCTIONS:

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Delaware Division of Public Health.

Any alteration of this document is prohibited. Do not accept unless on security paper with the raised seal of the Office of Vital Statistics.

State Registrar





Tax ID Number Change Request

Customer's Name: MARIAN BLACKWELL Date: 12/23/2014

Account #: 0210717179

TIN/SSN Change

TIN/SSN changed due to: Change Primary Reporting

Current TIN/SSN: 211200747
New TIN/SSN: 476629214

Additional Comments: CONVERTED TO AN ESTATE ACCOUNT

By signing this form I/we hereby acknowledge receipt of the disclosure of the terms and conditions for the services requested herein and agree to be bound by them. Under penalty of perjury, I (we) certify: (1) that the number(s) shown on this form is/are correct tax payer identification(s) and (2) that I (we) are not subject to backup withholding, either because I (we) have not been notified that I (we) are subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service (IRS) has notified me (us) that I (we) are no longer subject to back up withholding. (If section (2) is not correct, strike out that section.) The IRS does not require your consent to any provision of the document other than the certifications required to avoid backup withholding.

Brian K Blackwell

Customer Signature

12/23/14

Date

For Bank Use Only

Interoffice completed forms to the CIS Department.

Request received by:	Date:
TIN change processed?	Date:

Form SS-4

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

OMB No. 1545-0003

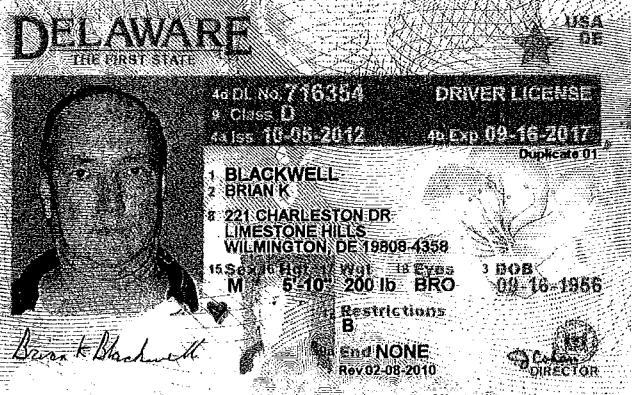
(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

► See separate instructions for each line. ► Keep a copy for your records.

EIN

47-6629214

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested	Marian L. BLACKWELL			
	2 Trade name of business (if different from name on line 1)	Brian K. BLACKWELL			
	4a Mailing address (room, apt., suite no. and street, or P.O. box)	5a Street address (if different) (Do not enter a P.O. box.)			
	4b City, state, and ZIP code (if foreign, see instructions)	5b City, state, and ZIP code (if foreign, see Instructions)			
	6 County and state where principal business is located	NEW CASTLE COUNTY, DE			
	7a Name of responsible party	7b SSN, ITIN, or EIN 221-46-8915			
	8a Is this application for a limited liability company (LLC) (or a foreign equivalent)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	8b If 8a is "Yes," enter the number of LLC members	
	8c If 8a is "Yes," was the LLC organized in the United States?	<input type="checkbox"/> Yes			<input type="checkbox"/> No
	9a Type of entity (check only one box). Caution. If 8a is "Yes," see the instructions for the correct box to check.	<input type="checkbox"/> Sole proprietor (SSN) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (enter form number to be filed) ► _____ <input type="checkbox"/> Personal service corporation <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Other nonprofit organization (specify) ► _____ <input type="checkbox"/> Other (specify) ► _____			
		<input checked="" type="checkbox"/> Estate (SSN of decedent) 211-20-0747 <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> National Guard State/local government <input type="checkbox"/> Farmers' cooperative Federal government/military <input type="checkbox"/> REMIC Indian tribal governments/enterprises Group Exemption Number (GEN) if any ► _____			
	9b If a corporation, name the state or foreign country (if applicable) where incorporated	State		Foreign country	
	10 Reason for applying (check only one box)	<input type="checkbox"/> Banking purpose (specify purpose) ► _____ <input type="checkbox"/> Started new business (specify type) ► _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Compliance with IRS withholding regulations <input checked="" type="checkbox"/> Other (specify) ► ESTATE			
	11 Date business started or acquired (month, day, year). See instructions.	12 Closing month of accounting year September			
	OCTOBER 26, 2014	<input type="checkbox"/> If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. <input type="checkbox"/>			
	13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	<input type="checkbox"/> Agricultural 0 Household 0 Other 0			
	15 First date wages or annuities were paid (month, day, year). Note. If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year)				
	16 Check one box that best describes the principal activity of your business.	<input type="checkbox"/> Health care & social assistance Wholesale-agent/broker <input type="checkbox"/> Construction Rental & leasing Transportation & warehousing Accommodation & food service Wholesale-other Retail <input type="checkbox"/> Real estate Manufacturing Finance & insurance Other (specify)			
	17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.				
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here ►					
Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.					
Third Party Designee	Designee's name Brian K. BLACKWELL		Designee's telephone number (include area code) (302) 300-4390		
	Address and ZIP code 121 Charleston Dr, Wilmington, DE 19808		Designee's fax number (include area code) ()		
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.					
Name and title (type or print clearly) ► Brian K. BLACKWELL					
Signature ► Brian K. BLACKWELL					
Date ►					





[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Brian K Blackwell
221 CHARLESTON DR
WILMINGTON, DE 198084358

SSN/TIN: 221-46-8915
DOB: 09/16/1956

DL#: 716364
DL State: DE

Home Phone: (302)354-7767

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

			<u>Code</u>	<u>Text</u>
QualiFile Score:	0812	Reasons:	DK	ASSET OWNERSHIP HISTORY
			DH	PROPERTY OWNERSHIP HISTORY
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1972 IN DE SSN:Y

DL Format: VALID DRIVERS LICENSE FORMAT

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Retail: NOTE * THERE IS NO RETAIL INDICATOR

Inquiry ID

681101445

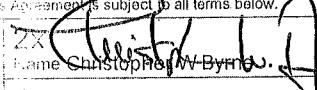
Reference Detail

OFAC OID#: 1656226584
Debit Bureau Reference#: 14LN52774821
Transaction Tracking ID: 1419367174201:64635:UXAP307P_Z1:
Location ID: OH

[Back To Top](#)

IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

Account Holder Names: ESTATE OF RICHARD C BYRNE CHRISTOPHER W BYRNE EXEC	ACCOUNT NUMBER: 210777942	WSFS Relationship Checking
Mailing Address: 45 E 25th St. Apt 14A New York NY 10010	ACCOUNT PURPOSE: Consumer	ACCOUNT TYPE: Personal
Home Phone: (917) 992-3263	OWNERSHIP TYPE: Estate	
Number of Signatures Required: 1	DATE OPENED: 12/22/2014	DATE REVISED:
Special Instructions:	VERIFIED BY: 	OPENED BY: Daniel Woods

Bank Center Branch

1X Name Richard C Byrne	2X Name Christopher W Byrne
3X Name	4X Name

Each of the Authorized Individual(s) credits that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage caused by such authority, provided, Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them in the Authorization Agreement or that the authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) sign(s) this jointly and severally, to the signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement and option to withdraw at any time, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable). All rights reserved. This is a continuing agreement to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of the deposit account agreement.

TIN/BUPAC WITHOLDING

Reporting SSN/TIN: 476673432

IMPORTANT: Under penalties of perjury, I certify that: 1) I am not subject to backup withholding (my identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting my Social Security number on my tax return (FATCA), and 4) I checked the appropriate box:

I am not subject to backup withholding because I am exempt from backup withholding or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends received. I understand that it is my responsibility to advise my personal tax preparer about backup withholding.

I am subject to backup withholding.

Date: 12/22/14

Signature of Authorized Individual

For instructions, see "Term Deposit Agreement" section of your account statement at the financial institution.

MMN = Mother's Maiden Name

The following information may be used to verify identity, employment, income, large transactions, or if a signature varies.

Signer #1: Richard C Byrne	SSN: 476673432
----------------------------	----------------

Street: 45 E 25th St. Apt 14A New York NY 10010

Mailing:

Home Phone #: (917) 992-3263

Employer:

DOB: 2/9/1932

DL/ID#:

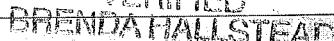
Work Phone #:

Occupation:

Birth Place:

MMN:

VERIFIED

Signer #2: Christopher W Byrne

Street: 45 E 25th St. 14A New York NY 10010

Mailing:

Home Phone #: (917) 992-3263

Employer:

DOB: 9/26/1952

DL/ID#: 178371444

Work Phone #:

Occupation:

Birth Place:

MMN:

CIN:

Signer #3:

Street:

Mailing:

Home Phone #:

Employer:

DOB:

DL/ID#:

Work Phone #:

Occupation:

Birth Place:

MMN:

CIN:

Signer #4:

Street:

Mailing:

Home Phone #:

Employer:

DOB:

DL/ID#:

Work Phone #:

Occupation:

Birth Place:

MMN:

CIN:

DEC 26 2014

NOTE: There may be only one signature per account. If there are multiple beneficiaries, Fiduciaries or Uniform Gifts to Minors Act. All fiduciaries appointed by order of court must each sign this signature card. Dependent Agent and appointed power are listed.

#298

ACCOUNT HOLDER NAMES: Richard C Byrne

ACCOUNT NUMBER: 210777942

Signatures of Adults and Individuals. This agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individuals (e.g. bank, phone instructions, large transactions, or if a signature varies).

MMN = Mother's Maiden Name

Signer #5:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #6:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #7:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #8:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #9:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #10:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Beneficiary/Payee Name and Address:	SSN:



NEW CASTLE COUNTY, SS.

I, Ciro Poppiti, III, Register of Wills for New Castle County, State of Delaware, do hereby certify that on the 9th day of DECEMBER, 2014, LETTERS TESTAMENTARY upon the Estate of RICHARD C. BYRNE, deceased, were in due form of law granted unto CHRISTOPHER W. BYRNE, who is/are now the Personal Representative(s) upon said estate, to all whose acts, as such, full faith and credit are to be given. I do further certify that the Personal Representative(s) is/are invested with full authority to direct and execute the transfer, assignment, or reissue of any stocks, bonds, documents of title, money in banks, or other securities of any incorporated company, being owned and held by the decedent at the time of his/her death and now constituting part of his/her personal estate. This appointment is still in full force and effect.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal,
this 9th day of DECEMBER, 2014.

File # 160002

An C Poppiti

Register of Wills



NOT VALID WITHOUT IMPRESSED SEAL

CERTIFICATION OF VITAL RECORD

**DEATH CERTIFICATION
State of Delaware
Department of Health and Social Services**

DECEDENT'S INFORMATION:

NAME: *RICHARD C BYRNE*

AKA's: NOT LISTED

SEX: MALE

DATE OF DEATH: NOV 18 2014

STATE FILE NUMBER: 107-14-007209

SOCIAL SECURITY NUMBER: 021-12-1435 ARMED FORCES: NO
DATE OF BIRTH: FEB 09 1922 AGE: 92 YEARS

PLACE OF DEATH INFORMATION:

TYPE: HOSPICE FACILITY

FACILITY NAME AND ADDRESS: COMPASSIONATE CARE HOSPICE INPATIENT AT ST FRANCIS, 19805

DISPOSITION INFORMATION:

METHOD: CREMATION

LOCATION: WILMINGTON, DELAWARE

PLACE: FAMILY CREMATION SERVICES

DEMOGRAPHIC INFORMATION:

RESIDENCE: 1013 Shalleross AVENUE, WILMINGTON, NEW CASTLE COUNTY, DELAWARE, 19806

PLACE OF BIRTH: CONNECTICUT

MARITAL STATUS: WIDOWED (AND NOT REMARRIED)

SURVIVING SPOUSE'S NAME: NOT LISTED

FATHER'S NAME: CHARLES CARROLL BYRNE

MOTHER'S NAME PRIOR TO FIRST MARRIAGE: JENNIE WASHBURN

INFORMANT'S INFORMATION:

INFORMANT'S NAME: ROBERT BYRNE

RELATIONSHIP: FAMILY MEMBER

MAILING ADDRESS: 213 NORWOOD HOUSE ROAD, DOWNTOWN, PENNSYLVANIA, 19935

FUNERAL HOME: MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON, NEW CASTLE COUNTY, DELAWARE, 19805

FUNERAL DIRECTOR: CHARLES F MEALEY JR. LICENSE NUMBER: K1-0000471

CAUSE OF DEATH - PART I

ACUTE TUBULAR NECROSIS RESULTING IN ACUTE RENAL FAILURE

SEPHSIS

PERITONITIS

PART II - LATE EFFECTS OF RIGHT HIP FRACTURE (REMOTE)

ME CONTACTED? NO

AUTOPSY PERFORMED? NO

AUTOPSY AVAILABLE?

ACTUAL OR PRESUMED TIME OF DEATH: 10:27

MANNER OF DEATH: NATURAL

INJURY INFORMATION:

DATE OF INJURY:

TIME OF INJURY:

INJURY AT WORK?

PLACE OF INJURY:

LOCATION OF INJURY:

HOW THE INJURY OCCURRED?

CERTIFIER NAME AND TITLE: DANIEL L DEPIETROPAOLO, MD.

LICENSE NUMBER: CT-0001998

CERTIFIER'S ADDRESS: 405 EAST MARSH LANE SUITE 4, NEWPORT, NEW CASTLE COUNTY, DELAWARE, 19804

DATE FILED: NOV 20 2014

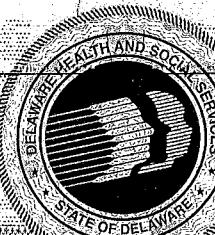
DATE OF ISSUANCE: NOV 21 2014

SPECIAL INSTRUCTIONS:

This is to certify that this is a true and correct
reproduction or abstract of the official record filed
with the Delaware Division of Public Health.

Any alteration of this document is prohibited. Do not
accept unless on security paper with the raised seal
of the Office of Vital Statistics.

State Registrar




[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

 Primary Signer**Consumer Information (As Entered)**

Christopher W Byrne
45 E 25th St. 14A
New York, NY 10010

SSN/TIN: 221-32-8379
DOB: 09/26/1956

DL#: 176371444
DL State: NY

Home Phone: (917)992-3263

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0793	Reasons:	Code	Text
			DK	ASSET OWNERSHIP HISTORY
			DH	PROPERTY OWNERSHIP HISTORY
			DB	TIME AT CURRENT ADDRESS
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1963 IN DE SSN:Y
DL Format: VALID DRIVERS LICENSE FORMAT

CheXSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Retail: NOTE * THERE IS NO RETAIL INDICATOR

Inquiry ID

680841557

Reference Detail

OFAC OID#: 1655983634
Debit Bureau Reference#: 14LM34427071
Transaction Tracking ID: 1419262427431:49119:UXAP303P_Z1:
Location ID: OH

[Back To Top](#)**IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES**

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).


[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Richard C Byrne
45 E 25th St. Apt. 14A
New York, NY 10010

SSN/ITIN: 476-67-3432
DOB: 02/09/1922

Home Phone: (917)992-3263

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0756	Reasons:	Code	Text
			DL	NO EVIDENCE OF ASSET OWNERSHIP
			DC	TIME AT CURRENT ADDRESS UNKNOWN
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY
			DH	PROPERTY OWNERSHIP HISTORY

Non FCRA**Identification Information**

SSN Validation: SSN AVAILABLE FOR RANDOMIZED ISSUANCE SSN:N

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Inquiry ID

680843188

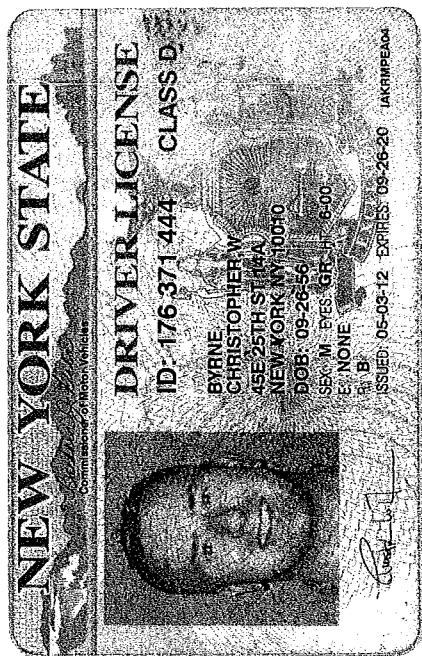
Reference Detail

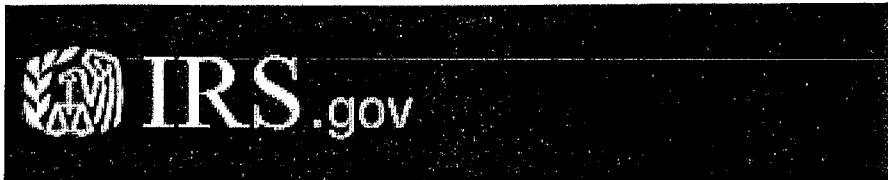
OFAC OID#: 1655985758
Debit Bureau Reference#: 14LM34821704
Transaction Tracking ID: 1419262821260:49975:UXAP304P_Z1:
Location ID: OH

[Back To Top](#)
IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

[Data Practices](#) [Privacy Policy](#) [Terms of Use](#)





EIN Assistant

Your Progress: 1. Identity 2. Authenticate 3. Addresses

Congratulations! The EIN has been successfully assigned.

EIN Assigned: **47-6673432**

Legal Name: **RICHARD C BYRNE ESTATE**

The confirmation letter will be mailed to the applicant. This letter will be the applicant's official IRS and will contain important information regarding the EIN. Allow up to 4 weeks for the letter to arrive mail.

We strongly recommend you print this page for your records.

Click "Continue" to get additional information about using the new EIN.

Continue :

Account Holder Names: ESTATE OF ESTHER DIANGELIS CAROL D MINCH EXEC		ACCOUNT NUMBER: 210788246 WSFS Interest Checking
Mailing Address: 140 W HILLENDALE RD, KENNETT SQUARE, PA, 19348-2651		ACCOUNT PURPOSE: Consumer
Home Phone: (610) 444-5051	Work Phone:	ACCOUNT TYPE: Personal
Number of Signatures Required: 1	CIF Number: 00000312224	OWNERSHIP TYPE: Estate
Special Instructions:		DATE OPENED: 12/22/2014
		DATE REVISED:
		VERIFIED BY: <i>Fennett</i>
		OPENED BY: Larry Ford

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x	2x <i>Carol D. Minch</i>
Name Esther Diangelis	Name Carol D Minch
3x	4x
Name	Name

Each of the authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, and Substitute Check Policy Disclosure, the Electronic Funds Transfer Agreement and Disclosure, (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING	Reporting SSN/TIN: 38-7126462-198-05-4257
Important: Under penalties of perjury, I certify that the number shown above is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (check appropriate box):	
<input checked="" type="checkbox"/> I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.	
<input type="checkbox"/> I am subject to backup withholding.	Date: 12/22/14
Signature of Authorized Individual <i>Carol D. Minch</i>	MMN = Mother's Maiden Name
For instructions, see Internal Revenue Service Form W-9 that is available at the financial institution.	

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

Signer #1: Esther Diangelis	SSN: 198-05-4257
Street: 140 W HILLENDALE RD KENNETT SQUARE PA 193482651	
Mailing: 140 W HILLENDALE RD, KENNETT SQUARE, PA, 19348-2651	
Home Phone #: (610) 444-5051	Work Phone #:
Employer:	Occupation:
DOB: 3/18/1918	Birth Place:
DL/ID#: 04118118	MMN:
Signer #2: Carol D Minch	SSN: 194324320

Street: 140 W HILLENDALE RD KENNETT SQUARE PA 193482651	
Mailing:	
Home Phone #: (610) 444-5051	Work Phone #:
Employer:	Occupation:
DOB: 12/14/1943	Birth Place:
DL/ID#: 15142098	MMN:
Signer #3:	SSN:

Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #4:	SSN:

Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
# 298	

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

DSMPF PA (Rev. 10/04) #7036E © Harland Financial Solutions, Inc. 2001,2004 All rights reserved.
To reorder, call Harland Financial Solutions at 877-505-8278.

Signatures of Authorized Individuals. This Agreement is subject to all terms on reverse.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies. MMN = Mother's Maiden Name

Signer #5: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #6: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #7: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #8: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #9: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #10: SSN:

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address: SSN:

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return) THE ESTATE OF ESTHER DiAngelis				
	Business name/disregarded entity name, if different from above				
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate				
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ► _____				
	<input type="checkbox"/> Other (see instructions) ► _____				
	Address (number, street, and apt. or suite no.) WSFS Bank 500 Delaware Ave Wilmington, DE 19801-		Requester's name and address (optional)		
	City, state, and ZIP code				
List account number(s) here (optional)					

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

--	--	--	--	--	--	--	--

Employer identification number

3	8	-	7	1	2	6	4	6	2
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ► <i>Carol A. Mucci, Esq.</i>	Date ► <i>12-22-14</i>
--------------	---	------------------------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

S H O R T C E R T I F I C A T E

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF CHESTER

File Number: 1514-2098

I, TERRI CLARK, Register of Wills, in and for the County of Chester in the Commonwealth of Pennsylvania, do hereby certify that on the 17th day of December, 2014

LETTERS TESTAMENTARY
on the Estate of:

ESTHER DIANGELIS, Deceased

were granted to:
CAROL D. MINCH

having first been qualified well and truly to administer the same. I further certify that no revocation of said Letters appears of record in my office.

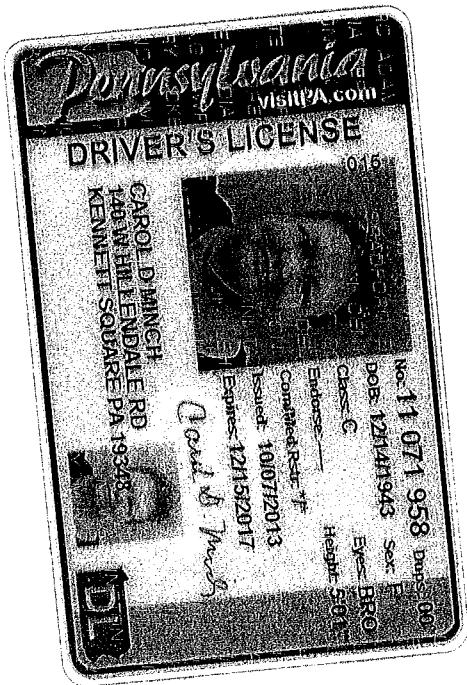
Date of Death: 11/07/2014
Soc. Sec. No.: 198-05-4257

Given under my hand and seal of office this
17th day of December, 2014



Deputy for the Register of Wills

NOT VALID WITHOUT ORIGINAL SIGNATURE AND IMPRESSED SEAL



CIS

STEP # 1 ---Document Prep

CIS WORK OF DATE:

12 24, 14
Month Day Year

2012

Associate: WB

OF DOCUMENTS

count includes separator sheets if multiple page

57

SINGLE PAGE (front only)

Legal Paper documents

MULTIPLE PAGE

separator sheets

Front & Back - double count

TYPE OF DOCUMENT: (Circle One)

Signature Cards

Title Updates

IRA

Business Documentation

Cash Management

Account Closes

Account Analysis

Other _____

STEP # 2 ---Scanning Process

Scanning Date

11/14/2014
MM DD Year

8:55:29
Time (Hour & Minutes)

Associate: WB

Scanning Count

Does this # Match # of documents?

(circle)

Yes or No

if No, Why ?

*re-count if needed

STEP # 3 ---Previewer Image Quality

Reviewer File Count

Does this # match # of Documents?

Yes

No

View customer's signatures ?

Yes

No

Is the Image blurry

Yes

No

Approve File

Associate: Deller

Any Issues with this previewer file, notify management for 2nd review.

Account Holder Name: ESTATE OF THEODORE H DOWALO LYNNE IACCARINO, CRAIG DOWALO EXEC		ACCOUNT NUMBER: 210764221 WSFS Core Checking
Mailing Address: 714 JAVELIN WAY, BEAR, DE, 19701		ACCOUNT PURPOSE: Consumer
Home Phone:	Work Phone:	ACCOUNT TYPE: Personal
Number of Signatures Required: 1	CIF Number: 00000625909	OWNERSHIP TYPE: Estate
Special Instructions:		DATE OPENED: 12/22/2014
		DATE REVISED:
		VERIFIED BY:
		OPENED BY: Melissa Mannerling

Airport Plaza

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x Name Theodore H Dowalo	2x Name Lynne Iaccarino
3x Name Craig Dowalo	4x Name Lynne Maccaro

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 476-67-8557

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

I am not subject to backup withholding because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding

Signature of Authorized Individual X

Date: 12/22/14

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Theodore H Dowalo

SSN: 476-67-8557

Street: 714 JAVELIN WAY BEAR DE 19701

Mailing:

Home Phone #:

Employer:

DOB: 4/14/1946

DL/ID#: 476678557

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #2: Lynne Iaccarino

SSN: 195645080

Street: 7105 Tuscany Drive Macungie PA 18062

Mailing:

Home Phone #:

Employer:

DOB: 10/15/1970

DL/ID#: 22241861

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #3: Craig Dowalo

SSN: 195645717

Street: 328 South Juniper Street Philadelphia PA 19107

Mailing:

Home Phone #:

Employer:

DOB: 9/27/1972

DL/ID#: 22864962

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #4:

SSN:

Street:

Mailing:

Home Phone #:

Employer:

DOB:

DL/ID#:

Work Phone #:

Occupation:

Birth Place:

MMN:

DEC 26 2014

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NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5x Name	6x Name
7x Name	8x Name
9x Name	10x Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #6:	SSN:
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Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #7:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #8:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #9:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #10:	SSN:
--------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address:	SSN:
--	-------------

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 12-15-2014

Employer Identification Number:
47-6678557

Form: SS-4

Number of this notice: CP 575 B

THEODORE H DOWALO II ESTATE
LYNN M IACCARINO ADM
714 JAVELIN WAY
BEAR, DE 19701

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN 47-6678557. This EIN will identify your estate or trust. If you are not the applicant, please contact the individual who is handling the estate or trust for you. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 1041

04/15/2015

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.


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Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Lynne Iaccarino
7105 Tuscany Drive
Macungie, PA 18062

SSN/ITIN: 195-64-5080
DOB: 10/15/1970
DL#: 22241861
DL State: PA

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0788	Reasons:	Code	Text
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY
			DH	PROPERTY OWNERSHIP HISTORY
			DB	TIME AT CURRENT ADDRESS
			DK	ASSET OWNERSHIP HISTORY

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1984 IN PA SSN:Y
DL Format: VALID DRIVERS LICENSE FORMAT

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Retail: NOTE * THERE IS NO RETAIL INDICATOR

Inquiry ID
680932805**Reference Detail**

OFAC OID#: 1656061046
Debit Bureau Reference#: 14LM52363921
Transaction Tracking ID: 1419280363896:58275:UXAP304P_Z2:
Location ID: OH

[Back To Top](#)**IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES**

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

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Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Estate Of Theodore H Dowalo II
 714 Javelin Way
 Bear, DE 19701

SSN/ITIN: 476-67-8657
 DOB: 04/14/1946

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0807	Reasons:	Code	Text
			DL DH	NO EVIDENCE OF ASSET OWNERSHIP PROPERTY OWNERSHIP HISTORY

Non FCRA**Identification Information**

SSN Validation: SSN AVAILABLE FOR RANDOMIZED ISSUANCE SSN:N

ChexSystems® History

No Closures Found
 No Purchased Debt Found
 No Previous Inquiries Found

Inquiry ID

680937150

Reference Detail

OFAC OID#: 1656066338
 Debit Bureau Reference#: 14LM53138240
 Transaction Tracking ID: 1419281138302:51054:UXAP307P_Z2:
 Location ID: OH

[Back To Top](#)
IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

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CERTIFICATION OF VITAL RECORD

OFFICE OF VITAL
STATISTICS

CERTIFICATE OF DEATH

State of Delaware
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

(107)

State File Number

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)												12. SEX	13. SOCIAL SECURITY NUMBER		
Theodore H. Dowalo, Jr.												male	169-36-7139		
4a. AGE - Last Birthday (Years)		4b. UNDER 1 YEAR		4c. UNDER 1 DAY		4d. DATE OF BIRTH (Mo/Day/Yr.)		4e. BIRTHPLACE (City and State or Foreign Country)							
68		Months	Days	Hours	Minutes	April 14 1946		Washington, Pennsylvania							
7a. RESIDENCE STATE Delaware		7b. COUNTY New Castle		7c. CITY OR TOWN Bear		7d. STREET AND NUMBER 714 Javelin Way		7e. APT. NO. 19701		7f. ZIP CODE 19701		7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Civil Union		10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)											
11. FATHER'S NAME (First, Middle, Last) Theodore H. Dowalo						12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Pauline Frohman									
13a. INFORMANT'S NAME Lynne Iaccarino		13b. RELATIONSHIP TO DECEDENT daughter		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 7105 Tuscan Dr., Macungie, PA 18062											
14. PLACE OF DEATH (Check only one; See Instructions)															
15. IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival						16. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify):						17. COUNTY OF DEATH New Castle			
18. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Embalming <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):						19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) Hockessin Crematory Company									
20. LOCATION-CITY, TOWN, AND STATE Wilmington, Delaware		21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY Chandler Funeral Home 2506 Concord Pike, Wilmington DE 19803													
22. SIGNATURE OF FUNERAL SERVICE LICENSED OR OF HER AGENT Daniel P. Solonice						23. LICENSE NUMBER (Or Licensee) K10000605									
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH						24. DATE PRONOUNCED DEAD (Mo/Day/Yr) 12/5/14						25. TIME PRONOUNCED DEAD 8:51 pm			
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) R. Roberts						27. LICENSE NUMBER C1-0008364						28. DATE SIGNED (Mo/Day/Yr) 12/5/14			
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) Dec 5 2014						30. ACTUAL OR PRESUMED TIME OF DEATH 8:51 pm						31. WAS MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
32. PART I. Enter the chain of events, diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.												Approximate Interval Onset to death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hepatorenal Failure Due to (or as a consequence of):															
b. Hepatocellular Cancer Due to (or as a consequence of):															
c. Squamous Cell Lung Cancer Due to (or as a consequence of):															
d. _____															
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I															
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown						36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year						33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
37. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined															
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)		39. TIME OF INJURY (Mo/Day/Yr) (Spell Month)		40. PLACE OF INJURY (e.g., Decedent's home, consultant's site, restaurant, wooded area)		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No									
42. LOCATION OF INJURY Street & Number				City or Town:		Apartment No.:		43. DESCRIBE HOW INJURY OCCURRED:							
44. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)															
45. CERTIFIER (Check only one): <input type="checkbox"/> Certifying physician To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & certifying physician To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.															
Signature of certifier Lynne Naimy, Jr.															
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Line 32) This is to certify that Lynne Naimy is doing business as Naimy's Funeral Home, Newark, DE 19712 Reproduction or abstract of this record is illegal. DATE CERTIFIED (Mo/Day/Yr) 12/10/14												47. FOR REGISTRATION ONLY DATE ISSUED (Mo/Day/Yr) DEC 11 2014			
48. DECEDENT'S PREGNANCY STATUS (Line 36) Any alteration of this document is prohibited. Do not accept unless on security paper with the raised seal of the Office of Vital Statistics.												49. STATE REGISTRAR Signature			

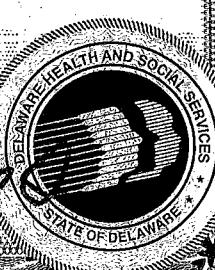
To Be Completed By:
MEDICAL CERTIFIER

To Be Completed By:
FUNERAL DIRECTOR

L 921756

NOTICE: THIS DOCUMENT IS SECURE

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE





NEW CASTLE COUNTY, SS.

I, Ciro Poppiti, III, Register of Wills for New Castle County, State of Delaware, do hereby certify that on the 22nd day of DECEMBER, 2014, LETTERS OF ADMINISTRATION upon the Estate of THEODORE H. DOWALO II, deceased, were in due form of law granted unto LYNNE M. IACCARINO and CRAIG S. DOWALO, who is/are now the Personal Representative(s) upon said estate, to all whose acts, as such, full faith and credit are to be given. I do further certify that the Personal Representative(s) is/are invested with full authority to direct and execute the transfer, assignment, or reissue of any stocks, bonds, documents of title, money in banks, or other securities of any incorporated company, being owned and held by the decedent at the time of his/her death and now constituting part of his/her personal estate. This appointment is still in full force and effect.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal,
this 22nd day of DECEMBER, 2014.

File # 160127

Ciro Poppiti

Register of Wills



NOT VALID WITHOUT IMPRESSED SEAL





ACCOUNT HOLDER NAMES: JOSEPH C MAHEK

ACCOUNT NUMBER: 210644852

Account Holder Names: JOSEPH C MAHEK SPECIAL NEEDS TRUST SAMANTHA MAHEK TRUSTEE		ACCOUNT NUMBER: 210644852 WSFS Direct Checking
Mailing Address: PO BOX 169 , DELAWARE CITY, DE, 19706		ACCOUNT PURPOSE: Consumer
Home Phone: (302) 304-1248	Work Phone:	ACCOUNT TYPE: Fiduciary
Number of Signatures Required: 1	CIF Number: 00000625614	OWNERSHIP TYPE: Trust
Special Instructions:		DATE OPENED: 12/16/2014
		DATE REVISED:
		VERIFIED BY: Janine Scherr
Bank Center Branch <small>Signatures of Authorized Individuals. This Agreement is subject to all terms below.</small>		
1x Name JOSEPH C MAHEK	2x Name Samantha Mahek	<i>Samantha Mahek</i>
3x Name	4x Name	

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 222-84-1631

IMPORTANT! Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):
 I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.
 I am subject to backup withholding.

Signature of Authorized Individual: *Samantha Mahek*

Date:

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: JOSEPH C MAHEK	SSN: 222-84-1631
Street: 213 JEFFERSON ST DELAWARE CITY DE 19706	
Mailing: PO BOX 169 , DELAWARE CITY, DE, 19706	
Home Phone #: (302) 304-1246	Work Phone #:
Employer:	Occupation:
DOB: 2/15/1984	Birth Place:
DL/ID#: 0441760	MMN:
Signer #2: Samantha Mahek	SSN: 222801119
Street: 213 Jefferson St. Delaware City DE 19706	
Mailing:	
Home Phone #: (302) 304-1246	Work Phone #:
Employer:	Occupation:
DOB: 3/21/1991	Birth Place:
DL/ID#: 9390747	MMN:
Signer #3:	SSN:
Street:	
Mailing:	
Home Phone #:	Work Phone #:
Employer:	Occupation:
DOB:	Birth Place:
DL/ID#:	MMN:
Signer #4:	SSN:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

DEC 26 2014

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ACCOUNT HOLDER NAMES: JOSEPH C MAHEK

ACCOUNT NUMBER: 210644852

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name
The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.	
Signer #6: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Signer #6: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Signer #7: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Signer #8: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Signer #9: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Signer #10: Street: Mailing: Home Phone #: Employer: DOB: DL/ID#:	SSN: Work Phone #: Occupation: Birth Place: MMN:
Beneficiary/Payee Name and Address:	



Trustee Certification of Deposit Powers

Account Number(s), 210644852

In consideration of WSFS Bank (hereafter "you") opening and/or maintaining one or more accounts for the Trust named below, I/we, the undersigned trustee(s) certify as follows:

1. The title and Taxpayers Identification Number of the Trust to which this certification applies are:

Title:

Joseph C. Mahek, Special Needs Trust

TIN or SS#: 222-84-1631

Use the same title and Taxpayer Identification Number that appears on the W-9 certification.

2. The date of the Trust is: April 19, 2007
3. There are no other Trustees of the Trust other than the undersigned.
4. You have the authority to accept orders and other instructions relative to accounts titled in the name of the Trust from the individuals or entities listed below. The following individuals or entities may execute any documents on behalf of the Trust which you may require.

Current Trustee Name(s) (Please Print)

Samantha Mahek

P.O. Box 159

Address

Bethany City, DE A706

Address

Address

5. Signature Authority (one box *must* be checked).

As sole Trustee, I have all necessary signature authority to bind the Trust and take the actions specified in Section 6.

The Trust Agreement provides that _____ of _____ Co-Trustee is the minimum number of Trustees required to sign to bind the Trust and take the actions specified in Section 6.

Initial S, M, M



6. I/We certify that I/we have the power under the Trust Agreement and applicable law to enter into the transactions below in the Trust's name and to execute any documents that are required to carry out such transactions (Strike statements that do not apply):
 - (A) The establishment and use of bank deposit accounts and certificates of deposit.
 - (B) The establishment and use of Safe Deposit Services.
7. I/We, individually and in my/our capacity as Trustees, jointly and severally, indemnify you and hold you harmless from any liability for effecting transactions at our requests, should you act pursuant to the instructions given by anyone listed in paragraph 4 above.
8. I/We, individually verify that the statements made in this certificate are true and correct. I/We understand that false statements herein are made subject to the penalties of 11 U.S.C. § 1344. I/We agree to inform you, in writing, of any material amendment to the Trust, any change in the composition of the Trustees, or any other event that could alter the certifications made above.

Signature of Trustees:

Samantha Mabek

12-18-14

Date

Date

All Current Trustees Must Sign

Date

Should only one person execute this agreement, it shall be a representation that the signer is the sole trustee. Where applicable plural references in this certification shall be deemed singular.

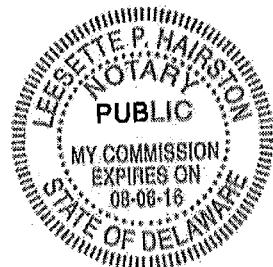
All signatures must be notarized.

County of New Castle
State/Commonwealth of Delaware SS.

BE IT REMEMBERED, that on this 18th day of December, 20 14, personally appeared before me, the subscriber, a Notary Public for the State/Commonwealth and county aforesaid, Samantha Mabek, who, being by me first duly sworn according to law, did depose and state that he/she did sign and deliver the within instrument/agreement as his/her voluntary act and deed.

WITNESSETH MY HAND AND SEAL

Leesette P. Hairston
NOTARY PUBLIC



Account Holder Names: ORIN W MARKS TRUST JANE L MARKS TRUSTEE MULTI PURPOSE		ACCOUNT NUMBER: 210733804 WSFS Core Checking
Mailing Address: 414 CONCORD AVE, WILMINGTON, DE, 19803-2316		ACCOUNT PURPOSE: Consumer
Home Phone: (302) 478-2068	Work Phone:	ACCOUNT TYPE: Fiduciary
Number of Signatures Required: 1	CIF Number: 00000043736	OWNERSHIP TYPE: Trust
Special Instructions:		DATE OPENED: 12/23/2014
		DATE REVISED:
		VERIFIED BY: Jeff Gonzalez
Fairfax Signatures of Authorized Individuals. This Agreement is subject to all terms below.		

1x Name Orin W Marks	2x Name Jane L Marks <i>Jane L. Marks</i>
3x Name	4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 523-34-7077

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions),

3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual X *Jane L. Marks*

Date: *Dec. 23, 2014*

For Instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Orin W Marks	SSN: 523-34-7077
-------------------------	------------------

Street: 414 CONCORD AVE WILMINGTON DE 198032316
Mailing: 414 CONCORD AVE, WILMINGTON, DE, 19803-2316
Home Phone #: (302) 478-2068
Employer:
DOB: 8/19/1928
DL/ID#: 5/27/14

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #2: Jane L Marks	SSN: 218249492
-------------------------	----------------

Street: 414 CONCORD AVE WILMINGTON DE 198032316
Mailing:
Home Phone #: (302) 478-2068
Employer:
DOB: 12/3/1930
DL/ID#: 494066

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #3:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:

Occupation:

Birth Place:

MMN:

Signer #4:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:

Occupation:

Birth Place:

MMN:

DEC 26 2014

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NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5x Name	6x Name
7x Name	8x Name
9x Name	10x Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #6:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #7:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #8:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #9:	SSN:
------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #10:	SSN:
-------------	------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address:	SSN:
-------------------------------------	------



Trustee Certification of Deposit Powers

Account Number(s), 210733804, _____, _____

In consideration of WSFS Bank (hereafter "you") opening and/or maintaining one or more accounts for the Trust named below, I/we, the undersigned trustee(s) certify as follows:

1. The title and Taxpayers Identification Number of the Trust to which this certification applies are:

Title:

Orin W. Marks Trust

TIN or SS#: 523-34-7077

Use the same title and Taxpayer Identification Number that appears on the W-9 certification.

2. The date of the Trust is: November 22, 1996

3. There are no other Trustees of the Trust other than the undersigned.

4. You have the authority to accept orders and other instructions relative to accounts titled in the name of the Trust from the individuals or entities listed below. The following individuals or entities may execute any documents on behalf of the Trust which you may require.

Current Trustee Name(s) (Please Print)

JANE L. MARKS

414 Concord Ave. Wilm. DE 19803

Address

Address

Address

5. Signature Authority (one box *must* be checked).

- As sole Trustee, I have all necessary signature authority to bind the Trust and take the actions specified in Section 6.
- The Trust Agreement provides that ____ of ____ Co-Trustee is the minimum number of Trustees required to sign to bind the Trust and take the actions specified in Section 6.

Initial JLM _____



6. I/We certify that I/we have the power under the Trust Agreement and applicable law to enter into the transactions below in the Trust's name and to execute any documents that are required to carry out such transactions (**Strike statements that do not apply**):
 - (A) The establishment and use of bank deposit accounts and certificates of deposit.
 - (B) The establishment and use of Safe Deposit Services.
7. I/We, individually and in my/our capacity as Trustees, jointly and severally, indemnify you and hold you harmless from any liability for effecting transactions at our requests, should you act pursuant to the instructions given by anyone listed in paragraph 4 above.
8. I/We, individually verify that the statements made in this certificate are true and correct. I/We understand that false statements herein are made subject to the penalties of 11 U.S.C. § 1344. I/We agree to inform you, in writing, of any material amendment to the Trust, any change in the composition of the Trustees, or any other event that could alter the certifications made above.

Signature of Trustees:

Jane L. Marks

Dec. 23, 2014

Date

Date

Date

All Current Trustees Must Sign

Should only one person execute this agreement, it shall be a representation that the signer is the sole trustee. Where applicable plural references in this certification shall be deemed singular.

All signatures must be notarized.

County of New Castle
State/Commonwealth of Delaware SS.

BE IT REMEMBERED, that on this 23 day of December, 2014, personally appeared before me, the subscriber, a Notary Public for the State/Commonwealth and county aforesaid, Jane L. Marks, who, being by me first duly sworn according to law, did depose and state that he/she did sign and deliver the within instrument/agreement as his/her voluntary act and deed.

WITNESSETH MY HAND AND SEAL

Jeffrey Gonzalez
NOTARY PUBLIC

JEFFREY GONZALEZ
NOTARY PUBLIC, STATE OF DELAWARE
MY COMMISSION EXPIRES JANUARY 9, 2019



County of _____
State/Commonwealth of _____ SS.

BE IT REMEMBERED, that on this _____ day of _____, 20_____, personally appeared before me, the subscriber, a Notary Public for the State/Commonwealth and county aforesaid, _____, who, being by me first duly sworn according to law, did depose and state that he/she did sign and deliver the within instrument/agreement as his/her voluntary act and deed.

WITNESSETH MY HAND AND SEAL _____
NOTARY PUBLIC

County of _____
State/Commonwealth of _____ SS.

BE IT REMEMBERED, that on this _____ day of _____, 20_____, personally appeared before me, the subscriber, a Notary Public for the State/Commonwealth and county aforesaid, _____, who, being by me first duly sworn according to law, did depose and state that he/she did sign and deliver the within instrument/agreement as his/her voluntary act and deed.

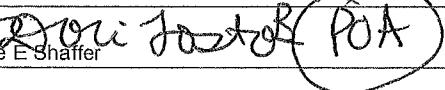
WITNESSETH MY HAND AND SEAL _____
NOTARY PUBLIC

Space Intentionally Left Blank

For Bank Use Only	Date	Branch	Officer	Account Number
----------------------	------	--------	---------	----------------

Account Holder Names: LISLE E SHAFFER		ACCOUNT NUMBER: 210612271	WSFS Direct Checking
Mailing Address: 19 WHITEHAVEN DR, NEW CASTLE, DE, 19720-3719		ACCOUNT PURPOSE: Consumer	ACCOUNT TYPE: Personal
Home Phone: (302) 544-4788	Work Phone: (302) 607-1036	OWNERSHIP TYPE: Single Owner	
Number of Signatures Required: 1	CIF Number: 00000055983	DATE OPENED: 12/17/2014	DATE REVISED:
Special Instructions:		VERIFIED BY: midway	OPENED BY: Mary Castelli

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x Name Lisle E Shaffer 	2x Name
3x Name	4x Name

Each of the Authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

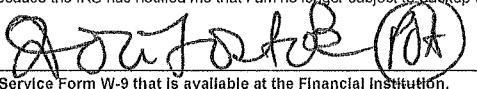
The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, Substitute Check Policy Disclosure, and the Electronic Funds Transfer Agreement and Disclosure (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Reporting SSN/TIN: 207-40-4014

IMPORTANT: Under penalties of perjury, I certify that 1) the number shown above is my correct taxpayer identification number, 2) I am a U.S. citizen or other U.S. person (defined in the instructions), 3) I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

- I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.
- I am subject to backup withholding.

Signature of Authorized Individual X  Date: _____

For instructions, see Internal Revenue Service Form W-9 that is available at the Financial Institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies. MMN = Mother's Maiden Name

Signer #1: Lisle E Shaffer	SSN: 207-40-4014
----------------------------	------------------

Street: 19 WHITEHAVEN DR NEW CASTLE DE 197203719

Mailing: 19 WHITEHAVEN DR, NEW CASTLE, DE, 19720-3719

Home Phone #: (302) 544-4788

Work Phone #: (302) 607-1036

Employer:

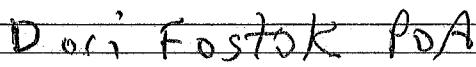
Occupation:

DOB: 12/26/1950

Birth Place:

DL/ID#:

MMN:

Signer #2: 

SSN: 163-62-7727

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #3:

SSN:

VERIFIED
DRENDA HALLSTEAD

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

Signer #4:

SSN:

Street:

Mailing:

Home Phone #:

Work Phone #:

Employer:

Occupation:

DOB:

Birth Place:

DL/ID#:

MMN:

DEC 26 2014

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NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

Signatures of Authorized Individuals. This Agreement is subject to all terms on page 1.

5X Name	6X Name
7X Name	8X Name
9X Name	10X Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

Signer #6:	SSN:
------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

Signer #7:	SSN:
------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

Signer #8:	SSN:
------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

Signer #9:	SSN:
------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

Signer #10:	SSN:
-------------	------

Street:	Work Phone #:
Mailing:	Occupation:
Home Phone #:	Birth Place:
Employer:	MMN:
DOB:	
DL/IID#:	

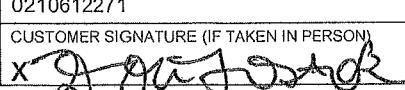
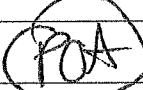
Beneficiary/Payee Name and Address:	SSN:
-------------------------------------	------

BRANCH	DATE PREPARED	PREPARED BY	APPROVED BY	ATM/POS/DEBIT CARD REQUEST FORM
Midway	12/17/2014	Castelli		

ISSUE CARDS TO:

CUSTOMER NAME LISLE E SHAFFER	CUSTOMER NAME
ADDRESS 19 WHITEHAVEN DR NEW CASTLE, DE 197203719	ADDRESS

ACCOUNT INFORMATION AND INSTRUCTIONS:

ACCOUNTS TO ACCESS WITH ATM CARD 0210612271	PRIMARY ACCOUNT 0210612271
CUSTOMER SIGNATURE (IF TAKEN IN PERSON)  	CUSTOMER SIGNATURE (IF TAKEN IN PERSON) X

The Combined ATM/POS/Debit Cards are to be setup/enabled-with the following features: (CHECK ALL THAT APPLY)

- AUTOMATED TELLER POINT OF SALE ENHANCED POINT OF SALE CHECK GUARANTEE SPECIAL
MACHINE ACCESS DEBIT CARD ACCESS DEBIT CARD ACCESS CARD INSTRUCTIONS: _____

NOTE: Point of Sale (POS) transactions or Point of Sale (POS) debit card transactions on the MasterCard¹ or VISA² network from your Combined ATM/POS/Debit Card will be deducted from the Primary Account listed above. Point of Sale (POS) transactions or Point of Sale (POS) debit card transactions involving a refund will be credited to your Primary Account. Unless you specify a different account during Automated Teller Machine (ATM) transactions, the Primary Account will be used for your transactions.

AUTHORIZATION:

I, (the Account Holder(s)) apply for a Combined Automated Teller Machine/Point Of Sale/Debit (ATM/POS/Debit) Card to be used in conjunction with the account(s) listed above. The Combined ATM/POS/Debit Card will be setup (pursuant to my request) with the functions or features indicated above and the usage of the Combined ATM/POS/Debit Card will be subject to the terms and conditions contained in the Deposit Account Agreement and Disclosure and Regulation E Disclosure that have been provided to me. I authorize the Financial Institution to make any investigation of my credit, either directly or through any agency. I understand that the Financial Institution will retain this application and any other credit information, even if this Combined ATM/POS/Debit Card is not granted. I agree not to use the ATM/POS/Debit Card Service in any illegal activity.

FOR INSTITUTION USE ONLY

DATE TAKEN	BY:
DATE APPROVED	BY:
CARD NUMBERS ASSIGNED	PIN:
DATA ENTRY DATE	BY:

¹MasterCard is a registered trademark of MasterCard International.
²VISA is a registered trademark of VISA International.

Durable Personal Power of Attorney Form

I certify that this is
a true and correct
copy of the original
Power of Attorney

As the person completing this form, you are the Principal. This form gives another person the power to act on your behalf. The other person is your Agent.

This form allows you to designate:

- (1) one Agent at a time and up to two Agents in succession;
- (2) two or more Agents who may act independently of each other (Concurrent Agents); or
- (3) two or more Agents who must act together (Joint Agents).

If your Agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor Agent(s).

IF YOU HAVE QUESTIONS ABOUT THIS POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT(S), YOU SHOULD SEEK LEGAL ADVICE BEFORE COMPLETING AND SIGNING THIS FORM.

Designation of Agent

I, Lisle Shaffer, name the following person(s) as my
(Name of Principal)

Agent(s):

Name of Agent: Dorie Fostok

Agent's Address: 510 Faraday Rd., Hockessin, DE 19707

Agent's Telephone Number: 281-763-9085

DESIGNATION OF ADDITIONAL OR SUCCESSOR AGENTS (OPTIONAL)

Name of Agent: _____

Agent's Address: _____

Agent's Telephone Number: _____

Name of Agent: _____

Agent's Address: _____

Agent's Telephone Number: _____

If more than one Agent has been named above, I intend for those Agents to:

- Act successively, one after the other.
 Act concurrently, independent of each other.
 Act jointly, such that neither may act alone.

You must sign ONE of these two choices:

Lisle E Shaffer

Sign here if this is your choice

This power of attorney is effective immediately, and shall not be affected by my subsequent incapacity.

Sign here if this is your choice

This power of attorney is effective only if and while I am incapacitated as determined under 12 Del. C. § 49A-109(c).

Grant of General Authority

You should READ the terms of each category of power or authority listed below before granting any of them to your Agent(s). A full explanation of each power or authority is in the Delaware Code. The Delaware Code is available online.

Search: Delaware Code, Title 12, Chapter 49A, and then go to the number next to the category. Example: Real Property, Section (§) 49A-204. The Delaware Code may also be available at your local library.

I grant my Agent(s) general authority to act for me with respect to the following categories of powers. INITIAL each category you want to include in the Agent's general authority. CROSS OUT each category you do not want to include in the Agent's general authority.

If you do not initial a category listed below, powers associated with that category will NOT be included as part of your Agent's general authority.

- CS
- Real Property § 49A-204
 Tangible Personal Property § 49A-205
 Stocks and Bonds § 49A-206
 Commodities and Options § 49A-207
 Banks and Other Financial Institutions § 49A-208
 Operation of Entity or Business § 49A-209
 Insurance and Annuities § 49A-210
 Estates, Trusts, and Other Beneficial Interests § 49A-211
 Claims and Litigation § 49A-212
 Personal and Family Maintenance § 49A-213
 Benefits from Governmental Programs or Civil or Military Service § 49A-214
 Retirement Plans § 49A-215
 Taxes § 49A-216
 Gifts § 49A-217

Grant of Specific Authority

Giving your Agent(s) any of the following powers will give your Agent(s) the authority to take actions that could significantly reduce your property or change how and to whom your property is distributed at your death.

You should READ the terms describing each power before granting any of them to your Agent(s). INITIAL each power you want to include in the Agent's authority. CROSS OUT each power you do not want to include in the Agent's authority.

If you do not initial a power listed below, it will NOT be included as part of your Agent's specific authority.

- I, S Create, amend, revoke, or terminate an inter vivos trust
- Make a gift in excess of the limitations provided in the Durable Personal Power of Attorney Act, 12 Del. C. § 49A-217
- Create or change rights of survivorship
- Create or change a beneficiary designation
- Delegate authority granted under the power of attorney when all successor Agents have resigned, died, become incapacitated, are no longer qualified to serve, or have declined to serve
- Exercise fiduciary powers that the Principal has authority to delegate
- Reject, renounce, disclaim, release, or consent to a reduction in or modification of a share in or payment from estate, trust, or other beneficial interest

Any person, including my Agent(s), may rely upon this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

Revocation of Prior Power of Attorney

If you have previously executed a power of attorney granting authority covered in this document, indicate below whether or not you wish to revoke the prior power of attorney. **Initial** your selection below:

All my previously executed powers of attorney are hereby revoked.

My previously executed powers of attorney hereby remain in effect.

Other. Explain. _____

IF YOU HAVE QUESTIONS ABOUT THIS POWER OF ATTORNEY OR THE AUTHORITY YOU ARE GRANTING TO YOUR AGENT(S), YOU SHOULD SEEK LEGAL ADVICE BEFORE SIGNING THIS FORM.

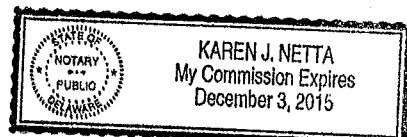
IN WITNESS WHEREOF, I have hereunto set my Hand and Seal this 15th day of December, 2014.

Lisle Shaffer
Principal's Signature
Lisle Shaffer
Print Principal's Name

SIGNED, SEALED, AND DECLARED by the Principal, _____, as his/her Durable Personal Power of Attorney in the presence of the following witness, who has signed in the presence of and at the request of the Principal on the day and year appearing above.

I, the witness, swear that I am not related to the Principal by blood, marriage, civil union, or adoption; and that I am not entitled to any portion of the estate of the Principal under the Principal's current will or codicil, or under any current trust instrument of the Principal.

Karen J. Netta of New Castle ^{DE} Hartland Hospice
(Seal) Witness Signature
Karen J. Netta
Print name

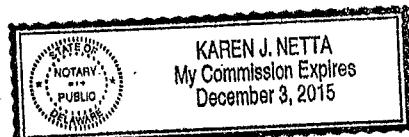


STATE OF DELAWARE :: SS.

COUNTY OF New Castle :

This Durable Power of Attorney was signed by the Principal, witnessed by the person aforesaid, and acknowledged before me, the Subscriber, a Notary Public, this 15th day of December 2014.

Karen J. Netta
Notary Public



Liability of Agent

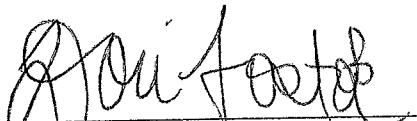
The authority granted to you is specified in the Durable Personal Power of Attorney Act, Delaware Code, Title 12, Chapter 49A. If you violate the Act, or act outside the scope of the authority granted, you may be liable for any damages caused by your violation.

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

Agent's Certification

I, Dorie Fostok, have read the attached durable power of attorney and the foregoing statement, and I am the person identified as the Agent for the Principal. To the best of my knowledge, this power has not been revoked. I hereby acknowledge that, in the absence of a specific provision to the contrary in the durable power of attorney, when I act as Agent:

- I shall exercise my powers for the benefit of the Principal.
- I shall keep the assets of the Principal separate from my assets.
- I shall exercise reasonable caution and prudence.
- I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the Principal.
- I shall, to the extent reasonably practicable under the circumstances, keep in regular contact with the Principal and communicate with the Principal.



Agent Signature

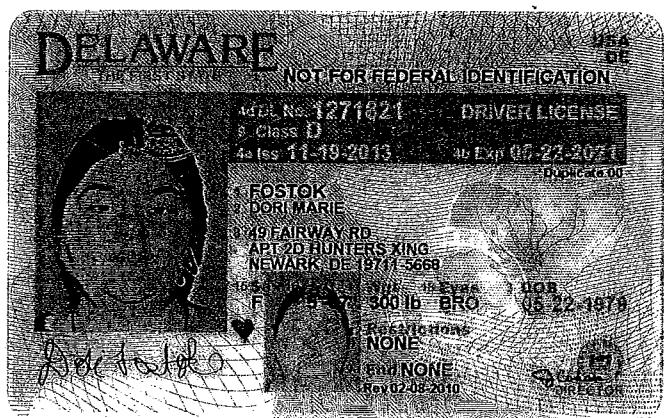
12-15-14

Date

Effective October 1, 2010

Effective October 1, 2010

CP as POA
for acct 210612271




[Print](#) | [View Information](#) | [Order Checks](#) | [New Inquiry](#) | [Logout](#) | [Contact Us](#) | [Help](#)

Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Lisle E Shaffer
19 WHITEHAVEN DR
NEW CASTLE, DE 197203719

SSN/ITIN: 207-40-4014
DOB: 12/26/1950

Home Phone: (302)544-4788

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0768	Reasons:	Code	Text
			DL	NO EVIDENCE OF ASSET OWNERSHIP
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY
			DH	PROPERTY OWNERSHIP HISTORY

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1966 IN PA SSN:Y

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Inquiry ID

680256719

Reference Detail

OFAC OID#: 1655402932
Debit Bureau Reference#: 14LH39356040
Transaction Tracking ID: 1418835356093:12858:UXAP307P_Z2:
Location ID: OH

[Back To Top](#)
IMPORTANT INFORMATION FOR CONSUMER REPORT & IDENTITY VERIFICATION SERVICES

This consumer/business data is being furnished in connection with a transaction initiated by the consumer, and / or in accordance with the written instructions of the consumer, to whom the information relates as provided for under the federal Fair Credit Reporting Act (FCRA) or the Gramm Leach Bliley Act (GLBA); or is being used in connection with account review as provided for under the FCRA. The data contained in this report may be viewed or printed for no other purpose. Information returned in Consumer Report services may not be viewed or printed in connection with making a pre-approved firm offer of credit (prescreen).

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Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

Lisle E Shaffer
19 WHITEHAVEN DR
NEW CASTLE, DE 197203719

SSN/ITIN: 207-40-4014
DOB: 12/26/1950

Home Phone: (302)544-4788

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0768	Reasons:	Code	Text
			DL	NO EVIDENCE OF ASSET OWNERSHIP
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY
			DH	PROPERTY OWNERSHIP HISTORY

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1966 IN PA SSN:Y

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Inquiry ID

680256719

Reference Detail

OFAC OID#: 1655402932
Debit Bureau Reference#: 14LH39356040
Transaction Tracking ID: 1418835356093:12858:UXAP307P_Z2:
Location ID: OH

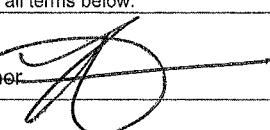
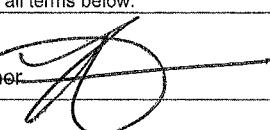
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Account Holder Names: EDNA MAYNOR OR Paul Maynor POA		ACCOUNT NUMBER: 210656062 WSFS Relationship Checking
Mailing Address: 5008 Devonshire CT, Landenberg, PA, 19350		ACCOUNT PURPOSE: Consumer
Home Phone: (610) 274-8803 Work Phone:		ACCOUNT TYPE: Personal
Number of Signatures Required: 1 CIF Number: 00000625500		OWNERSHIP TYPE: Joint Owners
Special Instructions:		DATE OPENED: 12/12/2014
		VERIFIED BY: <i>Kenneth S.</i>
		DATE REVISED: OPENED BY: Tami Reynolds

Signatures of Authorized Individuals. This Agreement is subject to all terms below.

1x  <i>POA</i>	2x 
Name Edna Maynor	Name Paul R Maynor
3x 	4x 
Name	Name

Each of the authorized Individual(s) certify that they have all required authority to act with respect to this account(s) and, jointly and severally, agree to indemnify and hold Financial Institution harmless from and against any loss or damage arising from such authority or lack thereof. Financial Institution has no responsibility or duty to assure or verify that Authorized Individual(s) have or are acting within the authority given them by the authorizing document or that such authorizing document is genuine or valid, even if Financial Institution has seen or retained a copy of such document.

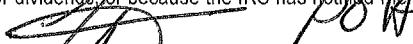
The Authorized Individual(s) signing agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, and Substitute Check Policy Disclosure, the Electronic Funds Transfer Agreement and Disclosure, (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

TIN/BACKUP WITHHOLDING

Important: Under penalties of perjury, I certify that the number shown above is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (check appropriate box):

I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

I am subject to backup withholding.

Signature of Authorized Individual  *POA*

Date: *12 DEC 2014*

For instructions, see Internal Revenue Service Form W-9 that is available at the financial institution.

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #1: Edna Maynor

SSN: 408344787

Street: 5008 Devonshire CT Landenberg PA 19350

Mailing:

Home Phone #: (610) 274-8803

Work Phone #:

Employer:

Occupation:

DOB: 3/23/1926

Birth Place:

DL/ID#:

MMN:

Signer #2: Paul R Maynor  *POA*

SSN: 413-08-7043

Street: 5008 DEVONSHIRE CT LANDENBERG PA 193501351

Mailing:

Home Phone #: (484) 734-0225

Work Phone #: (302) 521-0981

Employer:

Occupation:

DOB: 8/1/1963

Birth Place:

DL/ID#: 28 676 676

MMN: BOLEY

Signer #3:

Street:

Work Phone #:

Mailing:

Occupation:

Home Phone #:

Birth Place:

Employer:

MMN:

DOB:

SSN:

DL/ID#:

DEC 26 2014

#298

Signer #4:

Street:

Work Phone #:

Mailing:

Occupation:

Home Phone #:

Birth Place:

Employer:

MMN:

DOB:

SSN:

DL/ID#:

NOTE: There may be only one Custodian for an account under the Uniform Transfers to Minors Act or the Uniform Gifts to Minors Act. All fiduciaries appointed by order of a court must each sign this signature card. Depositor's Authorization Documents have not been filed.

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To reorder, call Harland Financial Solutions at 877-505-8278.

Signatures of Authorized Individuals. This Agreement is subject to all terms on reverse.

5x Name	6x Name
7x Name	8x Name
9x Name	10x Name

The following information may be used to further identify individual(s) for telephone instructions, large transactions, or if a signature varies.

MMN = Mother's Maiden Name

Signer #5:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #6:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #7:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #8:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #9:	SSN:
-------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Signer #10:	SSN:
--------------------	-------------

Street:
Mailing:
Home Phone #:
Employer:
DOB:
DL/ID#:

Work Phone #:
Occupation:
Birth Place:
MMN:

Beneficiary/Payee Name and Address:	SSN:
--	-------------

**DURABLE POWER OF ATTORNEY
WITH HEALTH CARE PROVISIONS**

I, EDNA PAULINE MAYNOR, a resident of Rhea County, Tennessee, do hereby REVOKE, *in toto*, the Powers of Attorney I previously executed and wherein I named MICHAEL DEAN MAYNOR and/or WILLIAM MCPHEETERS as my attorneys in fact (see Deed Book 427, page 543, Deed Book 427, page 545, and Deed Book 430, page 17, Register's Office Rhea County, Tennessee), and do hereby appoint PAUL R. MAYNOR AND MICHAEL D. MAYNOR, JOINTLY, to have the power to act as my true and lawful Attorney for me and in my name, place and stead, to ask, demand, sue for, collect and receive all sums of money, dividends, interest, payments on account of debt now due or which may hereafter become due and owing to me, and give good and valid receipts and discharges for such payments; to manage real property; to sell, convey and mortgage real estate or personal property; to take title to property in my name; to execute, acknowledge and deliver bills of sale as to personal property and deeds of real property, mortgages, releases and other instruments relating to real estate and personal property which he or she may consider necessary; to place in effect insurance; to do business with banks, particularly to endorse all checks and drafts made payable to my order, to collect the proceeds to sign in, my name, checks on all accounts standing in my name and to withdraw funds from said accounts, to open accounts in my name, and to have full access to the contents of any safe deposit box; to retain counsel and attorneys on my behalf, to appear for me in all actions and proceedings to which I may be a party in any Court, to commence actions and proceedings in my name, to sign and verify in my name all complaints, petitions, answers, and other pleadings of every description. I further grant to my attorneys any and all other powers enumerated in TENNESSEE CODE ANNOTATED §34-6-109.

To contract for my entry into, maintenance at, or release from any hospital, convalescent center, nursing home, or other health care facility, including the authority to approve or disapprove any proposed medical treatment to the extent that I am in the opinion of my treating physician, incompetent or incapable of acting for myself.

Hereby giving and granting to my said Attorney full power and authority to do and perform all and every act and thing whatsoever necessary to be done in the premises, as fully to all intents and purposes as I might or could do if present and acting personally, with full power of substitution and revocation, hereby ratifying and confirming all that my said Attorney-In-Fact

may do pursuant to this Power.

This Power of Attorney is given under the Uniform Durable Power of Attorney Act (T.C.A. 34-6-101 et seq.) and shall remain in full force and effect and will not be revoked by operation of law, nor shall it be affected by subsequent disability or incapacity. I intend for the authority conferred herein to be exercisable notwithstanding any such disability or incapacity.

I appointed the above person as my attorney in fact to make health care decisions for me whenever I am unable to do so.

I hereby execute this Durable Power of Attorney with Health Care Provisions on this the 8th day of November 2013.

Edna Pauline Maynor
EDNA PAULINE MAYNOR

State of Tennessee

County of Rhea

Personally appeared before me, Notary Public, EDNA PAULINE MAYNOR, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence) and who acknowledges that he/she executed the foregoing instrument for the purposes therein contained.

Witness my hand and official seal at Dayton, Tennessee this 8th day of November 2013.

JG
Notary Public
My commission expires: 6-21-2014

C:\Users\JG\Documents\My Documents\WMA\Maynor PAULINE DPOA.wpd

PREPARED BY:
J. SHANNON GARRISON
ATTORNEY AT LAW
1596 MARKET STREET, SUITE 3
DAYTON, TENNESSEE 37321

BK/PG: 431/428-429
13060557

2 PGX AL - DURABLE POWER OF ATTORNEY	DEBRA BACH 44782	10/09/2013 - 11:10 AM
VALUE	0.00	
MORTGAGE TAX	0.00	
TRANSFER TAX	0.00	
RECORDING FEE	10.00	
ARCHIVE FEE	0.00	
OP FEE	2.00	
REGISTER'S FEE	0.00	
TOTAL AMOUNT	12.00	

STATE OF TENNESSEE, RHEA COUNTY
GLADYS BEST
REGISTER OF DEEDS

STATE OF TENNESSEE, RHEA COUNTY
The foregoing instrument and certificate were noted in Note Book
Page 1110, which 1M Disc. 9, 2013
and recorded in Deed Book 4731, Page 428-429, 2013
Part 5, Book 200, Recording Fee 10.00, Total 12.00
Attest My Hand Receipt No. Glady's Best
Register Glady's Best
Deputy Glady's Best


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Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

Primary
Secondary
Tertiary
Consumer Information (As Entered)

Edna Maynor
5008 Devonshire CT
Landenberg, PA 19350

SSN/ITIN: 408-34-4787
DOB: 03/23/1926

Home Phone: (610)274-8803

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

		Reasons:	<u>Code</u>	<u>Text</u>
QualiFile Score:	0684		DI	NO EVIDENCE OF PROPERTY OWNERSHIP
			DL	NO EVIDENCE OF ASSET OWNERSHIP
			DC	TIME AT CURRENT ADDRESS UNKNOWN
			DE	NON-DEROGATORY PUBLIC RECORD HISTORY

Non FCRA**Identification Information**

SSN Validation: ISSUED IN 1951 OR BEFORE IN TN SSN:N

ChexSystems® History

No Closures Found
No Purchased Debt Found
No Previous Inquiries Found

Inquiry ID

679677268

Reference Detail

OFAC OID#: 1654890588
Debit Bureau Reference#: 14LC49893827
Transaction Tracking ID: 1418413893373:83973:UXAP303P_Z1:
Location ID: OH

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Transaction Type : OFAC + Qualifile

Strategy : None Selected

Order Destination : Production

**Consumer Information (As Entered)**

PAUL R MAYNOR
 5008 DEVONSHIRE CT
 LANDENBERG, PA 193501351

SSN/ITIN: 413-08-7043
 DOB: 08/01/1963
 DL#: 28 676 676
 DL State:

Home Phone: (484)734-0225

Country of Citizenship:

OFAC Detail

OFAC Match: PASSED

Account Actions

Action: ACCEPT

Recommended Actions: OPEN ACCOUNT

QualiFile® Detail

QualiFile Score:	0784	Reasons:	<u>Code</u>	<u>Text</u>
			CO	ASSET OWNERSHIP HISTORY
			CI	NON-DEROGATORY PUBLIC RECORD HISTORY
			CL	PROPERTY OWNERSHIP HISTORY
			CD	INSUFFICIENT DDA INQUIRY ACTIVITY SAME FI

Non FCRA**Identification Information**

SSN Validation: BECAME AVAILABLE FOR ISSUANCE IN 1973 IN TN SSN:Y

ChexSystems® History

Total Closures:	0	Total Purchased Debt:	0
Disputed:	0	Disputed:	0
Paid:	0	Paid:	0
Unpaid:	0	Unpaid:	0
Partially Paid:	0	Partially Paid:	0
Sold:	0	Sold:	0

Closure Details

No Closures Found

Purchased Debt Details

No Purchased Debt Found

Inquiry Details

Total Number of Inquiries: 1 Number of Inquiring FI's: 1

Inquiry Date	Consumer Name	Inquirer Name
07/19/2012	PAUL R MAYNOR	WILMINGTON SAVINGS FUND SOCIETY

Inquiry 1 of 1

Inquiry Date: 07/19/2012

Inquiry ID: 553064244

INQUIRY PERFORMED BY
 WILMINGTON SAVINGS FUND SOCIETY
 FAIRFAX SHOPPING CENTER
 2005 CONCORD PIKE
 WILMINGTON, DE 198032976

CONSUMER INQUIRED UPON
 000-00-0000
 PAUL R MAYNOR
 5008 DEVONSHIRE CT
 LANDENBERG, PA 19350-1351

Inquiry ID
679677252

Reference Detail

OFAC OID#: 1654890584
Debit Bureau Reference#: 14LC49891747
Transaction Tracking ID: 1418413890994:83971:UXAP303P_Z1:
Location ID: OH

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