DIE ÖSTERREICHISCHEN RECHTSANWÄLTE

Power of Attorney

by which I _____

Date of birth _____

grant power of attorney to the law firm

Dr Gerhard Preisl & Dr Helgar Schneider
Attorneys-at-law
Reichsstraße 5a, 6900 Bregenz, Austria

and further authorise them to represent me and my heirs in all matters before courts and administrative authorities, including tax authorities, as well as out of court, to initiate legal proceedings and to refrain from doing so, accepting all types of service, in particular lawsuits, judgements and land register decisions, lodging and withdrawing appeals, obtaining enforcement orders and interim injunctions and refraining from doing so, submitting all types of land register applications, including all types of priority notes and cancellation declarations, to conclude settlements of all kinds, to collect and receive money and monetary value and to provide legally valid receipts for them, to sell, pledge and take over movable and immovable property and rights, either for consideration or free of charge, to conclude credit or loan agreements, to submit conditional or unconditional declarations of acceptance of inheritance in inheritance matters, to submit declarations of assets, to draw up articles of association, to agree on arbitral awards and to appoint arbitrators, to appoint trustees and representatives with the same or lesser powers of attorney, and to do everything else they deem useful and necessary.

Data protection declaration:

I confirm that I have read the information sheet on the data protection declaration, which contains all the necessary information on the processing of data and my rights, and which can be viewed by me at any time at www.preisl-schneider.at / which has been handed to me.

Declaration on the waiver of banking secrecy
(delete if not applicable)

I agree that documents relating to me held by banks and credit institutions with which I am associated may be disclosed to my attorneys-at-law and that they may be provided with information without restriction.

Declaration of release from medical confidentiality
(delete if not applicable)

I agree that medical records relating to me held by doctors and hospitals where I have been treated may be disclosed to my attorneys-at-law and that they may be provided with information without restriction.

Date Signature