

FILE NOW: FILING FEE AFTER MAY 1ST IS \$550.00

FILED
Feb 23, 1999 8:00 am
Secretary of State

02-23-1999 90115 037 ***150.00

PROFIT CORPORATION ANNUAL REPORT 1999



FLORIDA DEPARTMENT OF STATE
Katherine Harris
 Secretary of State
 DIVISION OF CORPORATIONS

DOCUMENT # H57511

1. Corporation Name
WELL CARE HMO, INC.



Principal Place of Business
**6800 N DALE MABRY
 STE. 209-211
 TAMPA FL 33614
 US**

Mailing Address
**6800 N DALE MABRY
 STE. 209-211
 TAMPA FL 33614
 US**

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified
05/17/1985

4. FEI Number
59-2583622

5. Certificate of Status Desired **\$8.75 Additional Fee Required**

6. Election Campaign Financing-Trust Fund Contribution **\$5.00 May Be Added to Fees**

8. This corporation owes the current year Intangible Personal Property Tax. Yes No

2. Principal Place of Business
21

2a. Mailing Address
26

Suite, Apt. #, etc.
22 Suite 270-299

City & State
23

Zip Country
24 25

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City **FL** 85 Zip Code

9. Name and Address of Current Registered Agent

**RUTHORFORD, TOM
 11016 N. DALE MABRY
 TAMPA FL 33618**

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	PCD <input type="checkbox"/> DELETE	1.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	PATEL, PRADIP C.	1.2 NAME	address
STREET ADDRESS	11016 N.DALE MABRY	1.3 STREET ADDRESS	6800 N. Dale Mabry Suite 270-299
CITY-ST-ZIP	TAMPA FL	1.4 CITY-ST-ZIP	Tampa FL 33614
TITLE	SD <input type="checkbox"/> DELETE	2.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	SHAH, RUPESH R	2.2 NAME	address
STREET ADDRESS	11016 N. DALE MABRY	2.3 STREET ADDRESS	6800 N. Dale Mabry Suite 270-299
CITY-ST-ZIP	TAMPA FL	2.4 CITY-ST-ZIP	Tampa FL 33614
TITLE	VD <input type="checkbox"/> DELETE	3.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	PATEL, KIRAN	3.2 NAME	address
STREET ADDRESS	11016 N. DALE MABRY	3.3 STREET ADDRESS	6800 N. Dale Mabry Suite 270-299
CITY-ST-ZIP	TAMPA FL	3.4 CITY-ST-ZIP	Tampa FL 33614
TITLE	<input type="checkbox"/> DELETE	4.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		4.2 NAME	
STREET ADDRESS		4.3 STREET ADDRESS	
CITY-ST-ZIP		4.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	5.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		5.2 NAME	
STREET ADDRESS		5.3 STREET ADDRESS	
CITY-ST-ZIP		5.4 CITY-ST-ZIP	
TITLE	<input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		6.2 NAME	
STREET ADDRESS		6.3 STREET ADDRESS	
CITY-ST-ZIP		6.4 CITY-ST-ZIP	

14. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: _____ Date: 1/6/99 Davline Phone #: 813-290-6281

CR2E034 (11/98)