

**2003 FOR PROFIT CORPORATION
UNIFORM BUSINESS REPORT (UBR)**


FILED
Jul 07, 2003 8:00 am
Secretary of State

07-07-2003 90138 030 ***550.00

0046645 AV

DOCUMENT # K38096

1. Entity Name
FLORIDA HEALTH PLAN MANAGEMENT, INC.



Principal Place of Business
**3520 THOMASVILLE ROAD, SUITE 200
TALLAHASSEE FL 32308**

Mailing Address
**3520 THOMASVILLE ROAD, SUITE 200
TALLAHASSEE FL 32308**



2. Principal Place of Business
Suite, Apt. #, etc.

3. Mailing Address
Suite, Apt. #, etc.

City & State

City & State

Zip Country

Zip Country

CHECK HERE IF MAKING CHANGES

4. FEI Number **59-2977013**

Applied For
 Not Applicable

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

6. Name and Address of Current Registered Agent

**COHEN, GERALD M ESQUIRE
300 SOUTH PARK ROAD
HOLLYWOOD FL 33021**

7. Name and Address of New Registered Agent

Name

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

City **FL** Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

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

FILE NOW!!! FEE IS \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State

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

10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD SCOTT, STEVEN M M.D. 3520 THOMASVILLE RD., STE. 200 TALLAHASSEE FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	AS WEGNER, ANITA S 3520 THOMASVILLE RD., STE. 200 TALLAHASSEE FL	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S COHEN, GERALD M 300 SOUTH PARK ROAD HOLLYWOOD FL 33021	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D BERDING, R. JOSEPH 300 SOUTH PARK ROAD HOLLYWOOD FL 33021	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D HOGAN, J. MICHAEL M.D. 300 SOUTH PARK ROAD HOLLYWOOD FL 33021	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T KING, FELICIA 2828 CROASDALE DR. DURHAM NC 27705	<input type="checkbox"/> Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

12. 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 report or supplemental 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 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: *Signature Required* **SIGNATURE REQUIRED** 7-1-03 919-768-4101

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (10/02)