

2000 UNIFORM BUSINESS REPORT (UBR)

FILED
Feb 11, 2000 8:00 am
Secretary of State
 02-11-2000 90017 048 ****61.25

DOCUMENT # N93000005558

1. Entity Name

HEALTHYWAYS, INC.

Principal Place of Business 555 NORTH JEFFERSON STREET MONTICELLO FL 32344		Mailing Address 555 NORTH JEFFERSON STREET MONTICELLO FL 32344-2060		AU0ZU4UJ DO NOT WRITE IN THIS SPACE
2. Principal Place of Business Suite, Apt. #, etc.		3. Mailing Address Suite, Apt. #, etc.		
City & State		City & State		
Zip	Country	Zip	Country	4. FEI Number 59-1143105 <input type="checkbox"/> Applied For <input type="checkbox"/> Not Applied
				5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent MILLER, GEORGE W 240 WEST WASHINGTON STREET MONTICELLO FL 32344			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.

SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____
Signature, typed or printed name of registered agent and title if applicable.

FILE NOW: FEE IS \$61.25	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	Make Check Payable to Department of State
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10	
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME	DEMOTT, HERBERT G	NAME	
STREET ADDRESS	ROUTE 1 BOX 197	STREET ADDRESS	
CITY-ST-ZIP	MONTICELLO FL 32344	CITY-ST-ZIP	
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME	GUPPY, HAROLD	NAME	
STREET ADDRESS	P.O. BOX 626 N/A	STREET ADDRESS	
CITY-ST-ZIP	MONTICELLO FL	CITY-ST-ZIP	
TITLE	PD <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME	WRIGHT, GARY	NAME	
STREET ADDRESS	P.O. BOX 340 N/A	STREET ADDRESS	
CITY-ST-ZIP	MONTICELLO FL	CITY-ST-ZIP	
TITLE	STD <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME	GRUBBS, JANA	NAME	
STREET ADDRESS	RT 1 BOX 163 B	STREET ADDRESS	
CITY-ST-ZIP	LAMONT FL 32336	CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/>
NAME		NAME	
STREET ADDRESS		STREET ADDRESS	
CITY-ST-ZIP		CITY-ST-ZIP	

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 617, Florida Statutes; and that my name appears in Block 10 or Block 11, or on an attachment with an address, with all other like empowered.

SIGNATURE: SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #