

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED

06 OCT -3 PM 12:18

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P02000030834

1. Corporation Name

HEALTHNET CORP.

2. Principal Office Address

11381 SW 129ct

Suite, Apt. #, etc.

3. Mailing Office Address

SAHIE

Suite, Apt. #, etc.

City & State

MIAMI FLORIDA

Zip

33186

Country

USA

Zip

Country

REINSTATEMENT

04-080

4. Date Incorporated or Qualified
To Do Business in Florida

04/04/2002

5. FEI Number

020589025

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75. Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

MIGUEL CESPEDAS

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

11381 SW 129ct MIA-FL-33186

Suite, Apt. #, Etc.

City

MIAMI

State

FL

Zip Code

33186

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

[Signature]

REGISTERED AGENT MUST SIGN

Date 10/02/06

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
PRES.	MIGUEL CESPEDAS	11381 SW 129ct	MIA-FL-33186

210080688252
10/11/06--01060--002 **450.00

10. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(l), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE:

[Signature]

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

10/02/06 786 399-2328

Daytime Phone #

K. Eckel OCT - 3 2006

DATE: 10/02/06 2/2

FL. DEPARTMENT OF STATE
ANNUAL REPORT

PER OUR CONVERSATION PLEASE CHECK YOUR RECORDS THAT MY

CORPORATION HEALTH NET CORP

DOCUMENT # PD 20000 36834

NEVER RECEIVED THE ANNUAL REPORT THIS YEAR. PLEASE ACCEPT OUR
PAYMENT WITHOUT PENALTY DUE TO THAT WE NEVER RECEIVED THE
REPORT.

THANKING YOU IN ADVANCE


SIGNATURE

MIGUEL CRESPO
PRINT NAME/ TITLE