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Secretary of State

PROFIT CORPORATION ANNUAL REPORT

1997

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **605732** **(7)**

1. Corporation Name
WAKULLA INSURANCE AGENCY, INC.

Principal Place of Business	Mailing Address
HWY 319 NAT HICKORY AVE PO BOX 400 CRAWFORDVILLE FL 32326	HWY 319 NAT HICKORY AVE PO BOX 400 CRAWFORDVILLE FL 32326-0400

3. Date Incorporated or Qualified: 01/05/1979
3a. Date of Last Report: 07/30/1996

4. FEI Number: 59-1884752 ☐ Applied For ☐ Not Applicable

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 has liability for intangible tax under s. 199.032, Florida Statutes ☒ Yes ☐ No

2. Principal Place of Business	2a. Mailing Address
21 7 Hickory Ave	26 P.O. Box 400
Suite, Apt. #, etc. 22	Suite, Apt. #, etc. 27
City & State 23 Crawfordville FL.	City & State 28 Crawfordville, FL
Zip 24 32327 Country 25 WAKULLA	Zip 29 32326-0400 Country 30 WAKULLA

9. Name and Address of Current Registered Agent

BARBREE, JOSEPH ALTON
153 OAK ST
CRAWFORDVILLE FL 32326

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

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
Signature, typed or printed name of registered agent and title if applicable.

12. OFFICERS AND DIRECTORS			13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12		
TITLE	VD	☐ DELETE	11 TITLE		☐ Change ☐ Addition
NAME	BARBREE, ELEANOR S		12 NAME		
STREET ADDRESS	153 OAK ST		13 STREET ADDRESS		
CITY-ST-ZIP	CRAWFORDVILLE FL		14 CITY-ST-ZIP		
TITLE	PD	☐ DELETE	21 TITLE		☐ Change ☐ Addition
NAME	BARBREE, JOSEPH A		22 NAME		
STREET ADDRESS	153 OAK ST		23 STREET ADDRESS		
CITY-ST-ZIP	CRAWFORDVILLE FL		24 CITY-ST-ZIP		
TITLE		☐ DELETE	31 TITLE		☐ Change ☐ Addition
NAME			32 NAME		
STREET ADDRESS			33 STREET ADDRESS		
CITY-ST-ZIP			34 CITY-ST-ZIP		
TITLE		☐ DELETE	41 TITLE		☐ Change ☐ Addition
NAME			42 NAME		
STREET ADDRESS			43 STREET ADDRESS		
CITY-ST-ZIP			44 CITY-ST-ZIP		
TITLE		☐ DELETE	51 TITLE		☐ Change ☐ Addition
NAME			52 NAME		
STREET ADDRESS			53 STREET ADDRESS		
CITY-ST-ZIP			54 CITY-ST-ZIP		
TITLE		☐ DELETE	61 TITLE		☐ Change ☐ Addition
NAME			62 NAME		
STREET ADDRESS			63 STREET ADDRESS		
CITY-ST-ZIP			64 CITY-ST-ZIP		

CR2E034 (9/96)

14. I do 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.

SIGNATURE: Eleanor S. Barbree ELEANOR S. BARBREE 4-9-97 904-926-8213 904-926-7055
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #