

846494

Florida Department of State  
Division of Corporations  
Electronic Filing Cover Sheet

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((H230003477203))



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To: Division of Corporations  
Fax Number : (850)617-6380

From: Account Name : C T CORPORATION SYSTEM  
Account Number : FCA000000023  
Phone : (954)208-0845  
Fax Number : (614)573-3996

\*\*Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.\*\*

Email Address: \_\_\_\_\_

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COR AMND/RESTATE/CORRECT OR O/D RESIGN  
UNICARE LIFE & HEALTH INSURANCE COMPANY

|                       |         |
|-----------------------|---------|
| Certificate of Status | 0       |
| Certified Copy        | 1       |
| Page Count            | 04      |
| Estimated Charge      | \$43.75 |

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DocuSign Envelope ID: 522FE226-57A1-4FF5-98C6-D90C14593D72

PROFIT CORPORATION  
APPLICATION BY FOREIGN PROFIT CORPORATION TO FILE AMENDMENT TO APPLICATION FOR  
AUTHORIZATION TO TRANSACT BUSINESS IN FLORIDA  
(Pursuant to s. 607.1504, F.S.)

SECTION I  
(1-3 MUST BE COMPLETED)

846496

(Document number of corporation (if known))

UNICARE LIFE & HEALTH INSURANCE COMPANY

(Name of corporation as it appears on the records of the Department of State)

Indiana

07/15/1980

(Incorporated under laws of)

(Date authorized to do business in Florida)

SECTION II  
(4-7 COMPLETE ONLY THE APPLICABLE CHANGES)

4. If the amendment changes the name of the corporation, when was the change effected under the laws of its jurisdiction of incorporation? \_\_\_\_\_

Wellpoint Life and Health Insurance Company

(Name of corporation after the amendment, adding suffix "corporation," "company," or "incorporated," or appropriate abbreviation, if not contained in new name of the corporation)

(If new name is unavailable in Florida, enter alternate corporate name adopted for the purpose of transacting business in Florida)

6. If the amendment changes the period of duration, indicate new period of duration

(New duration)

7. If the amendment changes the jurisdiction of incorporation, indicate new jurisdiction

(New jurisdiction)

8. If amending the registered agent and/or registered office address in Florida, enter the name of the new registered agent and/or the new registered office address:

Name of New Registered Agent \_\_\_\_\_

(Florida street address)

New Registered Office Address \_\_\_\_\_, Florida

(City)

(Zip Code)

New Registered Agent's Signature, if changing Registered Agent:

I hereby accept the appointment as registered agent. I am familiar with and accept the obligations of the position.

\_\_\_\_\_  
Signature of New Registered Agent, if changing

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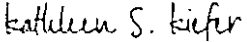
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9. If the amendment changes person, title or capacity in accordance with 607.1504 (4), indicate that change.

| <u>Title/Capacity</u> | <u>Name</u> | <u>Address</u> | <u>Type of Action</u> |
|-----------------------|-------------|----------------|-----------------------|
| _____                 | _____       | _____          | Add                   |
| _____                 | _____       | _____          | Remove                |
| _____                 | _____       | _____          | Add                   |
| _____                 | _____       | _____          | Remove                |
| _____                 | _____       | _____          | Add                   |
| _____                 | _____       | _____          | Remove                |
| _____                 | _____       | _____          | Add                   |
| _____                 | _____       | _____          | Remove                |

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 SECRETARY OF STATE

10. Attached is a certificate or document of similar import, evidencing the amendment, authenticated not more than 90 days prior to delivery of the application to the Department of State, by the Secretary of State or other official having custody of corporate records in the jurisdiction under the laws of which it is incorporated

DocuSigned by:  
  
 (Signature of a director, president or other officer - if in the hands of a receiver or other court appointed fiduciary, by that fiduciary)

Kathleen S. Kiefer  
 (Typed or printed name of person signing)

Secretary  
 (Title of person signing)

FILING FEE \$35.00

State of Indiana  
Office of the Secretary of State

Certificate of Fact

To Whom These Presents Come, Greeting:

I, DIEGO MORALES, Secretary of State of Indiana, do hereby certify that I am, by virtue of the laws of the State of Indiana, the custodian of the corporate records and the proper official to execute this certificate.

I further certify that records of this office disclose that

**WELLPOINT LIFE AND HEALTH INSURANCE COMPANY**

filed Articles of Amendment on September 11, 2023, changing their name from Unicare Life & Health Insurance Company to Wellpoint Life and Health Insurance Company.



In Witness Whereof, I have caused to be affixed my signature and the seal of the State of Indiana, at the City of Indianapolis, October 02, 2023

*Diego Morales*

DIEGO MORALES  
SECRETARY OF STATE

2005081700149 / 20233395251

All certificates should be validated here: <https://bsd.sos.in.gov/ValidateCertificate>

Expires on November 01, 2023.