


SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 17, 1997.
AMOUNT DUE ON OR BEFORE 9/17/97: \$550 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$750.)

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PROFIT CORPORATION ANNUAL REPORT 1997		FLORIDA DEPARTMENT OF STATE Sandra B. Mortham Secretary of State DIVISION OF CORPORATIONS
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DOCUMENT # F96000003165 (5)

1. Corporation Name
CNA HEALTH PARTNERS, INC.

Principal Place of Business
CNA PLAZA, 43S
CHICAGO IL 60685

Mailing Address
CNA PLAZA, 43S
CHICAGO IL 60685

FILED

97 SEP -2 AM 10: 09

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



DO NOT WRITE IN THIS SPACE

2. Principal Place of Business 21 CNA Plaza Suite, Apt. #, etc. 22 City & State 23 Chicago, IL Zip 24 60685 Country 25 US		2a. Mailing Address 26 CNA Plaza Suite, Apt. #, etc. 27 Statutory Reporting-21S City & State 28 Chicago, IL Zip 29 60685 Country 30 US		3. Date Incorporated or Qualified 06/21/1996	3a. Date of Last Report
				4. FEI Number 36-4088829	Applied For Not Applicable
				5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required
				6. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/>	\$5.00 May Be Added to Fees
				8. This corporation owes or has paid the current year Intangible Personal Property Tax due June 30. <input type="checkbox"/> Yes <input type="checkbox"/> No	

9. Name and Address of Current Registered Agent C T CORPORATION SYSTEM 1200 SOUTH PINE ISLAND ROAD PLANTATION FL 33324		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	
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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 _____

12. OFFICERS AND DIRECTORS		13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	DC <input type="checkbox"/> DELETE	1.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	WITTLICH, JAE L	1.2 NAME	000002283910-4
STREET ADDRESS	CNA PLAZA, 40S	1.3 STREET ADDRESS	-03/03/97--01056--022
CITY-ST-ZIP	CHICAGO IL 60685	1.4 CITY-ST-ZIP	****165.00 ****165.00
TITLE	DV <input type="checkbox"/> DELETE	2.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	JOHNSON, THOMAS B	2.2 NAME	
STREET ADDRESS	CNA PLAZA	2.3 STREET ADDRESS	
CITY-ST-ZIP	CHICAGO IL 60685	2.4 CITY-ST-ZIP	
TITLE	DP <input type="checkbox"/> DELETE	3.1 TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	MATEJA, GLENN A	3.2 NAME	
STREET ADDRESS	CNA PLAZA, 44S	3.3 STREET ADDRESS	
CITY-ST-ZIP	CHICAGO IL 60685	3.4 CITY-ST-ZIP	
TITLE	V <input type="checkbox"/> DELETE	4.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	GENGLER, MICHAEL T	4.2 NAME	CNA Plaza
STREET ADDRESS	CNA PLAZA, 43S	4.3 STREET ADDRESS	
CITY-ST-ZIP	CHICAGO IL 60685	4.4 CITY-ST-ZIP	
TITLE	VT <input type="checkbox"/> DELETE	5.1 TITLE	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	DEMPSEY, PAMELA S	5.2 NAME	CNA Plaza
STREET ADDRESS	CNA PLAZA, 41S	5.3 STREET ADDRESS	
CITY-ST-ZIP	CHICAGO IL 60685	5.4 CITY-ST-ZIP	
TITLE	S <input type="checkbox"/> DELETE	6.1 TITLE	<input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition
NAME	RIBIKAWSKIS, MARY A	6.2 NAME	AV Pierce, Cathy J.
STREET ADDRESS	CNA PLAZA, 43S	6.3 STREET ADDRESS	CNA Plaza
CITY-ST-ZIP	CHICAGO IL 60685	6.4 CITY-ST-ZIP	Chicago, IL 60685

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 _____ 7/25/97 310-283-1225

CR2E034 (4/97)

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CNA Plaza Chicago IL 60685-0001

July 29, 1997

Florida Department of State
Sandra B. Mortham, Secretary of State
Division of Corporation
Attn: Annual Report Department
Post Office BOX 6327
Tallahassee, FL 32314

Re: 1997 Annual Report and Filing Fee

Dear Ms. Mortham:

Enclosed are the completed Annual Report Form and the required filing fee for the above company.

Financial Brokerage, Inc.	\$165.00
CNA Health Partners, Inc.	\$165.00

If you have any questions or concerns, please feel free to contact me.

Very truly yours,

NOTE: We did not receive the original invoice. Per Carol Anderson of Florida Ins. Dept. to pay \$165 only per company.

Milagros H. Cruz
Manager
Statutory Reporting - 21S
(312) 822-4650