2002 UNIFORM BUSINESS REPORT (UBR)

FILED
Sep 11, 2002 8:00 am
Secretary of State
09-11-2002 90129 030 ***150.00

DOCUMENT #, G74688

1. Entity Name
DECOPLANT, INC.

Principal Place of Business	Mailing Address
9035 S.W. 102ND COURT % GILBERTO COVER MIAMI FL 33176	9035 S.W. 102ND COURT % GILBERTO COVER MIAMI FL 33176

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 59-2339099 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

6. Name and Address of Current Registered Agent

COVER, GILBERTO
9035 S.W. 102ND COURT
MIAMI FL 33176

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

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back) ☐

FILE NOW!!! FEE IS $150.00
After May 1, 2002 Fee will be $550.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS			12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DP COVER, GILBERTO 9035 SW 102ND CT MIAMI, FL 00000	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D COVER, IVONNE FERO DE 9035 S.W. 102ND COURT MIAMI FL	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
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13. 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 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: ______________________ 9/10/02 305-261-5464
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CR2E034 (9/01)

Attachment 980071

DECOPLANT, INC.

6746 85

9035 S.W. 102nd COURT
MIAMI, FL 33176
FAX: (305) 264-5477 ☎:(305) 261-5464

TO: FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
UNIFORM BUSINESS REPORT FILINGS
REF: LATE FEE WAIVER

Dear Sir:

I'm requesting that you waive the late fee for filing the 2002 Uniform Business Report after the May 1, 2002 date.

I have never filed late and I honestly thought I had filed it and paid the $ 150.00 fee. This has really been an involuntary mistake, due to the distress and tension caused by illnesses in my family.

My brother, while visiting from Venezuela, had a Heart attack in my house, which required emergency surgery and several days in intensive care at Baptist Hospital and then rest in my home to recover before returning to his home.

My wife and Partner in Decoplant, Ivonne Cover, was hospitalized in January 19, 2002 through Jan 22, due to acute DIVERTICULITIS and she had to stay home taking antibiotics, get a Colonoscopy and recuperate and in April 26 was admitted to the Hospital with a perforated Colon for Inpatient Surgery. They removed 12" of her Colon. This required several days in the Hospital and 5 weeks recovery at home. (Copy of both Authorizations by the Insurance Company is attached as well as short term disability Certification). All this time I had to take care of her and my daughters and the business at the same time. Honestly, I was going crazy with so many problems and got a severe depression.

I plead to you to waive the late charges and allow me to pay the regular fee of $ 150.00 (CHECK ATTACHED).

Thanking you in advance for your consideration, I remain;

Very truly yours,

Gilberto Cover

INTRACORP
PARK LANE OFFICE CENTER
3200 PARK LANE DRIVE
PITTSBURGH PA 15275-1102

Attachment
980071
G74688

CIGNA HealthCare

Telephone: 800.244.6224

January 22, 2002

IVONNE COVER
9035 S.W. 102 CT
MIAMI FL 33176

Re: Participant: IVONNE COVER
Participant ID #: 26292280401
Reference Code: BCT9Q8K1
Intracorp,
on behalf of your Employer Plan
Authorization Effective Date(s): 01/19/2002
through 01/22/2002
Total Approved Day(s): 3

Dear IVONNE COVER:

We've received a coverage request from MARK CARUSO, MD on 01/21/2002 for IVONNE COVER for the following service/procedure(s):

- Approved: INPATIENT ADMISSION

After a thorough review of the information submitted, and the terms of your benefit plan, we have determined that the requested services will be covered. Your request has been authorized for the above listed services if you are enrolled and eligible for benefits on the date of service. It is important for you to know this letter does not guarantee payment of benefits under your health benefit plan if you are not enrolled and eligible for benefits on the date of service.

If you wish to obtain additional services from this provider, you or your provider must call our Customer Services Department at the toll-free phone number listed on your CIGNA HealthCare ID card to obtain advance approval. All services must be medically necessary. Some services may require prior authorization to be eligible for coverage.

If you have any questions about this letter or the terms of your benefit plan, please call our Customer Services Department at the toll-free phone number listed on your CIGNA HealthCare ID card. One of our representatives will be happy to help you.

Sincerely,

BONNIE CAMPBELL

BONNIE CAMPBELL, RN
Care Facilitator
Intracorp

c: MARK CARUSO, MD
BAPTIST HOSPITAL OF MIAMI

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Intracorp*, CIGNA Behavioral Health, Inc., and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

INTRACORP
PARK LANE OFFICE CENTER
3200 PARK LANE DRIVE
PITTSBURGH PA 15275-1102

Attachment
98UU71
G74688

CIGNA HealthCare

Telephone: 800.244.6224

April 22, 2002

IVONNE COVER
9035 S.W. 102 CT
MIAMI FL 33176

Re: Participant: IVONNE COVER
Participant ID #: 26292280401
Reference Code: BFNJBSK1
Intracorp,
on behalf of your Employer Plan
Authorization Effective Date(s): 04/26/2002
through 04/29/2002
Total Approved Day(s): 3

Dear IVONNE COVER:

We've received a coverage request from GUSTAVO PLASENCIA, MD on 04/22/2002 for IVONNE COVER for the following service/procedure(s):

- Approved: Inpatient surgical admission. (44202)

After a thorough review of the information submitted, and the terms of your benefit plan, we have determined that the requested services will be covered. Your request has been authorized for the above listed services if you are enrolled and eligible for benefits on the date of service. It is important for you to know this letter does not guarantee payment of benefits under your health benefit plan if you are not enrolled and eligible for benefits on the date of service.

If you wish to obtain additional services from this provider, you or your provider must call our Customer Services Department at the toll-free phone number listed on your CIGNA HealthCare ID card to obtain advance approval. All services must be medically necessary. Some services may require prior authorization to be eligible for coverage.

If you have any questions about this letter or the terms of your benefit plan, please call our Customer Services Department at the toll-free phone number listed on your CIGNA HealthCare ID card. One of our representatives will be happy to help you.

Sincerely,

JAMIE SOSTARICH

JAMIE SOSTARICH
Health Services Specialist
Intracorp

c: GUSTAVO PLASENCIA, MD
HEALTHSOUTH DOCTORS HOSPITAL

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Baptist Hospital of Miami

An Affiliate of Baptist Health Systems of South Florida

Attachment 9KOUD 674688

COVER, IVONNE
11/16/50 F/51 Y EDA
0010509594/0000651571
1/19/02 CARUSO, MARK
Ivonne Cover
32-08

GENERIC PATIENT / FAMILY TEACHING PLAN

PLAN TO BE INITIATED WITHIN 24 HOURS OF ADMISSION

ADMITTING DIAGNOSIS perforated viscous, diverticulitis

Signs and Symptoms

Review Physician's order sheet. When instructed, initial the following which apply

Testing	Procedures / Treatments	Medications	Activity	Equipment / Diet
Xrays .... CT abd A	I+O .... AR	Antibiotics .... AR	Activity BR	Diet .... AR
Blood work .... AR	IV Fluids .... AR	PRN: Pain		Increased oral fluids ....
Pulse Ox		Other ______		
ABGs				
EKG				
Urine				
Glucometer				

I acknowledge understanding of diagnosis and initial treatment plan Date 1/20/02 Patient/family Initials IC

Health care professionals providing teaching, please record **initials and signatures**

AR [signature]

Discharge Instructions

(Nursing procedures demonstrated, ie. Feeding, dressings, injections, catheter care)
Take all medications as instructed and follow all instructions.

Avoid

Discuss with your doctor

Notify your doctor as soon as possible if any of the following symptoms occur

- Elevated temperature above 100° for more than 24 hours
- Any new symptoms or change in symptoms you are experiencing now

Abdominal discomfort, fever, sweats, nausea vomiting, diarrhea or constipation.

Evaluation

Patient/Family able to verbalize and demonstrate understanding of discharge instructions given MK

Information Resource

I understand the information provided and will contact my doctor with any further questions.

Signature of Patient / Responsible Person X Ivonne Ferro de Cover

Signature of Nurse MKaiser Date 1/22/02

DO NOT WRITE IN THIS SPACE

WHITE - MEDICAL RECORDS YELLOW - PATIENT

Bank of America Attachment 98071 674688

Short Term Disability/Medical Leave
Certification of Health Care Provider
Part I – Associate's Authorization for Release of Medical Information

Associate's Printed Name: Ivonne Cover
Associate's SSN: 262-92-2804

Associate contact information while on leave:
ADDRESS: 9035 SW 102 CT Miami, Fl. 33171
PHONE NUMBER: (305) 279-2614
EMERGENCY CONTACT NAME & PHONE NUMBER: ( )

The purpose of this form is to determine the associate's certification for a Family and Medical Leave Act (FMLA) protected leave and/or to receive paid benefits under the Bank of America Short Term Disability (STD) program. ***Please make sure that the form is filled out completely by your doctor to avoid delays in processing.***

Associate Instructions: ASSOCIATE TO COMPLETE PAGE 1

- ☐ Sign the appropriate authorization(s) (see directions below) releasing medical information from your doctor to the Bank of America Leave of Absence area to determine your eligibility for STD, FMLA, and/or unpaid Medical leave.
- ***If you are applying for a paid STD leave of absence in addition to FMLA, you must complete both Part 1 and Part 2 below.***
- ***If you are applying only for an unpaid medical leave of absence and /or FMLA leave , please complete only Part 2 below. If you do not qualify for FMLA protection, this section will still need to be completed by your doctor to be considered for your unpaid medical leave.***
- ☐ Print your name and social security number on pages 1 through 4 of the "Certification of Health Care Provider" form.
- ☐ Fill out the associate contact information on page 1.
- ☐ Submit the "Certification of Health Care Provider" form (Pages 1 through 5) to your treating physician's office for completion. Your doctor needs to complete only the sections that are related to the type of leave that you are requesting.
- *If your condition has already been diagnosed by your doctor, you may not need an appointment to have your doctor complete this form. You can send the form to the nurse for completion and doctor's signature, and then the nurse can return the form to the Pe rsonnel Center.*
- *The Personnel Center must receive your completed form within 28 days from your leave initiation date to prevent your pay, if applicable, from being impacted.*
- ☐ Have your doctor's office return the form directly to the Personnel Center.
- *You will be responsible for paying any fees to your doctor associated with your application for leave.*
- ☐ The Personnel Center will provide you with written notification within 5 business days upon receipt of your medical information from your doctor. Once your leave has been processed, you will be notified directly by the Personnel Center regarding your leave's approval or denial. If you have questions regarding your leave of absence, you may contact the Personnel Center at 1.800.556.6044, TDD 1.800.930.8044.

Associate Authorization:

PART 1: Short-Term Disability (STD) ***(To be completed only by associate seeking paid leave pursuant to the Bank of America STD Policy.)***
I certify that the statements below are to the best of my knowledge and belief, true, correct and complete. I hereby authorize my employer to contact my attending physician, practitioner, hospital, insurance company, and my claim administrators to seek additional information regarding my medical condition and I hereby authorize these health care and insurance provider(s) to furnish to my employer and to MetLife Insurance company, or any of their authorized representatives, all facts concerning my medical condition and disability that are within their knowledge, and to allow inspection of, and provide copies of any medical records (including any data protected by Federal Regulations 42 CFR Part 2, or other applicable laws: information concerning mental illness, HIV, AIDS, HIV-related illnesses and sexually transmitted diseases or other serious communicable diseases unless prohibited by applicable laws and/or regulations). I hereby authorize and direct my employer to release to MetLife any of my personnel records which relate to my claim for Long Term Disability and/or Bridge Pay benefits including, but not limited to, information on absences and earnings.

I understand that this information may be used to determine my eligibility for, and to compute the proper amount of benefits under Short Term Disability, State Disability Insurance, Long Term Disability, Workers' Compensation and any other benefit plan or practice of my employer which requires an evaluation of physical or mental conditions; including, but not limited to, leave from work for medical reasons. I acknowledge my right to revoke this authorization at any time. If I do not, it will be valid for 24 months from the date I sign it. A photocopy of this authorization is as valid as the original form.

Associate's Signature ____________________ Date ____________

PART 2: Family and Medical Leave Act (FMLA) ***(To be completed by ALL associates.)***
I authorize a health care provider representing my medical department to contact the health care provider signing this certification for purposes of clarification and authenticity of this certification. **I understand that it is my responsibility for paying any charges associated with completing this certification and the approval process.**

Associate's Signature ____________________ Date ____________

Attachment 980071 674688

Short Term Disability/Medical Leave
Certification of Health Care Provider
Part II – Health Care Provider Information

Associate's Printed Name: Ivonne Cover **Associate's SSN:** 26292-2804

Health Care Provider Instructions:

☐ Complete the section(s) (see definitions below) of the "Certification of Health Care Provider" form that pertain to your patient's leave of absence.

- SECTION 1: *Bank of America Short Term Disability (STD) / Paid Leave Authorization*
  Complete this section if the associate will be out of work due to their own illness, and only if the associate is seeking a paid leave pursuant to the Bank of America STD policy. (Note: Section 2 must also be completed.)
- SECTION 2: *FMLA Certification of Serious Health Condition Authorization*
  Complete this section if the associate will be out of work due to their own illness.
  (Includes FMLA Leave and unpaid Medical Leave) (Note: Section 2 must be completed for all patients.)

☐ Provide detailed (complete) information to avoid requests for additional information.

☐ Complete and sign **SECTION 3:** ***Health Care Provider Information*** at the end of the form.

☐ Return the form (Pages 1-4) directly to:

Bank of America Personnel Center
Attn: Leave of Absence Coordinators
401 N. Tryon Street
NC1-021-05-19
Charlotte, NC 28255
1.800.556.6044 , TDD: 1.800.930.8044

OR

FAX TO:
Bank of America Personnel Center
Attn: Leave of Absence Coordinators
704.632.6503

SECTION 1 (TO BE COMPLETED BY DOCTOR)

Bank of America Short Term Disability (STD) / Paid Leave Authorization:

Complete by doctor only if associate signed Part 1 on Page 1 of this form.

Bank of America is concerned about the health and well-being of its associates. The Short Term Disability (STD) program is designed to help associates who are unable to work due to their own illness, injury or pregnancy disability during their own serious illness by providing income protection for some or all of the associate's leave. Therefore, if the associate wishes to apply for pay through the STD program, they are required to provide the information through their health care provider. Your prompt and thorough response will allow timely processing of the associate's leave.

Your help and cooperation are certainly appreciated.

Sincerely,

William R. Bullock
William R. Bullock, MD
Bank of America Medical Director

Jimmie W. Adcock, MD
Bank of America Medical Director

1. A complete description of the type of disability or illness, including the diagnosis: Diverticulitis severe Abdominal pain

2. Describe relevant medical facts which support your diagnosis (Hospitalization/Confinements/Due Dates/Surgery/Etc.) In the case of pregnancy complications, if the associate is incapacitated prior to the baby's birth, please explain the specific condition. (i.e., pre-term labor, early cervical dilation, etc.): Had surgery Laparoscopic Sigmoid Colectomy ; umbilical hernia repair

3. How does this condition prevent the associate from working? PT unable To stand, sit or walk For prolonged periods of Time. PT Taking pain medication Percocet 1 Q4H PRN pain

Attachment 282271 #6 74688

Short Term Disability/Medical Leave
Certification of Health Care Provider
Part II – Health Care Provider Form (Continued)

Associate's Printed Name: Ivonne Cover **Associate's SSN:** 262-92-2804

SECTION 1 (CONTINUED):

4. Describe prognosis: PT will recover completely will be able To return To work on 6-10-02

5. In your medical opinion, the Bank of America associate will be able to return to work on: 6-10-02
Please provide specific date

6. a. If any treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

   b. If a regimen of continuing treatment of the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment, etc.):

IF SECTION 1 IS COMPLETED, SECTION 2 MUST ALSO BE COMPLETED.

SECTION 2 (MUST BE COMPLETED FOR ALL PATIENTS)

FMLA Certification of Serious Health Condition Authorization:

Complete by doctor if associate signed Part 2 on Page 1 of this form. Note: This section is required for all doctors.

1. a. The attached sheet (please refer to attached "FMLA Definition of 'Serious Health Condition'") describes what is meant by a "serious health condition" under the Family and Medical Leave Act.

   Does the patient's condition [1] qualify under any of the categories described? ☑ Yes ☐ No

   b. If so, please check the applicable category(ies):

   ☑ (1) Hospital ☑ (2) Absence plus Treatments ☐ (3) Pregnancy ☐ (4) Chronic plus Treatments
   ☐ (5) Long Term ☑ (6) Multi-Treatments ☐ None of the above

2. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

   Few months prior 4-4-02 (Date of Condition Commencement) | work To go back To 6-10-02 (End Date of Condition Duration) | 6-10-02 (End Date of Present Incapacity (If Different))

   b. Will it be necessary for the patient to work only intermittently / reduced schedule as a result of the condition (including treatment described in question 3 of this section)? unable to work

   ☐ Yes ☑ No If yes, give probable duration:

   c. If the condition is a chronic condition ("Chronic plus Treatments") or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

   Presently Incapacitated: ☑ Yes ☐ No If yes, duration and frequency: 6-10-02

3. a. If additional treatments will be required for the condition, provide an estimate or the probable number of such treatments:

   Estimated Number of Treatments

[1] *Here, the information sought relates only to the condition for which the associate is taking an FMLA Leave of Absence.*

[2] *"Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.*

Attachment 980071 674684

Short Term Disability/Medical Leave
Certification of Health Care Provider
Part II – Health Care Provider Form (Continued)

Associate's Printed Name: Ivonne Cover **Associate's SSN:** 262-92-2804

SECTION 2 (CONTINUED):

3. b. If the patient will be absent from work or other daily activities because of treatments needed on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any:
PT unable To stand, walk or sit For prolonged periods of Time. PT on pain medication.

4. a. If medical leave is required for the patient's absence from work because of the patient's own condition (including absence due to pregnancy complications or a chronic condition), is the patient unable to perform work of any kind? ☒ Yes ☐ No

b. If able to perform some work, is the patient unable to perform any one or more of the essential functions of the patient's job (the patient or the employer should supply you with this information about the essential job functions)? ☐ Yes ☒ No
If yes, please list the essential functions the patient is unable to perform: PT unable To work.

c. If neither "a" nor "b" applies, is it necessary for the patient to be absent from work for treatment? ☐ Yes ☐ No

SECTION 3 (MUST ALSO BE COMPLETED FOR ALL PATIENTS)

Health Care Provider Information:

Gustavo Plasencic M.D.
Printed Name of Health Care Provider

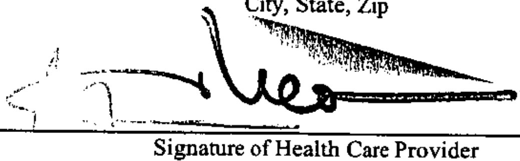
Colo. Rectal Surgeon
Type of Practice

9195 Sunset Dr #230
Address

305-271-0300
Telephone Number

Miami Fl. 33173
City, State, Zip

305-279-1994
Fax Number


Signature of Health Care Provider

5-6-02
Date