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May 01, 1999 8:00 am
Secretary of State

05-01-1999 90094 047 ***150.00

PROFIT CORPORATION ANNUAL REPORT

1999

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # J28248

1. Corporation Name
HUMANA MEDICAL PLAN, INC.

Principal Place of Business	Mailing Address
500 W MAIN ST. P.O. BOX 740026 ATTN: TAX DEPT. LOUISVILLE KY 40201-8438	500 W MAIN ST. P.O. BOX 740026 ATTN: TAX DEPT. LOUISVILLE KY 40201-8438

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualifed: 08/12/1986

2. Principal Place of Business	2a. Mailing Address
21	26
Suite, Apt. #, etc. 22	Suite, Apt. #, etc. 27
City & State 23	City & State 28
Zip 24 Country 25	Zip 29 Country 30

4. FEI Number: 61-1103898 ☐ Applied For ☐ Not Applicable

5. Certifcate 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 owes the current year Intangible Personal Property Tax. ☐ Yes ☐ No

9. Name and Address of Current Registered Agent

CT CORPORATION SYSTEM
1200 S. PINE ISLAND ROAD
PLANTATION FL 33324

THE REGISTERED AGENT HAS BEEN CHANGED TO:
CORPORATION SERVICE COMPANY
1201 HAYS ST
TALLAHASSEE, FL 32301

10. Name and Address of New Registered Agent

81 Name

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

12. OFFICERS AND DIRECTORS			13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12		
TITLE	PD	☐ DELETE	1.1 TITLE		☐ Change ☐ Addition
NAME	WOLF, GREGORY H		1.2 NAME		
STREET ADDRESS	500 W MAIN ST		1.3 STREET ADDRESS		
CITY-ST-ZIP	LOUISVILLE KY		1.4 CITY-ST-ZIP		
TITLE	VD	☐ DELETE	2.1 TITLE		☐ Change ☐ Addition
NAME	MURRAY, JAMES E		2.2 NAME		
STREET ADDRESS	500 W MAIN ST		2.3 STREET ADDRESS		
CITY-ST-ZIP	LOUISVILLE KY		2.4 CITY-ST-ZIP		
TITLE	SRVD	☐ DELETE	3.1 TITLE		☑ Change ☐ Addition
NAME	CASH, W. LARRY		3.2 NAME	McCallister, Michael	
STREET ADDRESS	MCCALLISTER, MICHAEL B		3.3 STREET ADDRESS	500 W MAIN ST	
CITY-ST-ZIP	LOUISVILLE KY		3.4 CITY-ST-ZIP		
TITLE	S	☐ DELETE	4.1 TITLE		☐ Change ☐ Addition
NAME	LENAHAN, JOAN O.		4.2 NAME		
STREET ADDRESS	500 W MAIN ST		4.3 STREET ADDRESS		
CITY-ST-ZIP	LOUISVILLE KY		4.4 CITY-ST-ZIP		
TITLE	VP	☐ DELETE	5.1 TITLE		☐ Change ☐ Addition
NAME	BAUERNFEIND, GEORGE		5.2 NAME		
STREET ADDRESS	500 W MAIN ST.		5.3 STREET ADDRESS		
CITY-ST-ZIP	LOUISVILLE KY		5.4 CITY-ST-ZIP		
TITLE	VPCA	☐ DELETE	6.1 TITLE	VPT	☑ Change ☐ Addition
NAME	CARLISLE, DOUGLAS R.		6.2 NAME	Doucette, James	
STREET ADDRESS	500 W MAIN ST		6.3 STREET ADDRESS		
CITY-ST-ZIP	LOUISVILLE KY		6.4 CITY-ST-ZIP		

CR2E034 (11/98)

14. 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 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, with all other like empowered.

SIGNATURE: Gregory Bauernfeind SIGNATURE REQUIRED George Bauernfeind, VP-Tax 4-29-99
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #