

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

10 FEB 25 AM 7:19

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

500170628815  
02/26/10--01008--001 \*\*478.00

CR2E041 (11/09)

LIMITED LIABILITY  
COMPANY  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

DOCUMENT # L05000037607

1. Limited Liability Company's Name

A.M.T. Insurance Group LLC

2. Principal Office Address - No P.O. Box #

2385 Executive Center Dr

Suite, Apt. #, etc.

Suite 100

City & State

Boca Raton FL

Zip

33431

Country

USA

3. Mailing Office Address

2385 Executive Center Dr

Suite, Apt. #, etc.

Suite 100

City & State

Boca Raton FL

Zip

33431

Country

USA

4. State/Country of Formation

FL USA

5. Date Organized or Qualified  
To Do Business in Florida

6. FEI Number

20 2695213

Applied For

Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐

\$5.00 Additional Fee required  
for a Certificate of Status

8. Name and Address of Current Registered Agent

Name

Alan Topchuk

Street Address (P.O. Box Number is Not Acceptable)

2385 Executive Center Dr

Suite, Apt. #, Etc.

Suite 100

City

Boca Raton FL

State

FL

Zip Code

33431

☐ A \$100 reinstatement fee is imposed, except  
in circumstances which the entity did not  
receive the prior notices. By checking this  
box, you are certifying the prior notices were  
not received and requesting the \$100  
reinstatement be waived.

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of  
Registered Agent

[Signature]

REGISTERED AGENT MUST SIGN

Date 2-24-10

10. Names and Street Addresses of Managing Members/Managers

Titles	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
<u>MEM</u> <u>Managing</u> <u>Member</u>	<u>Alan Topchuk</u>	<u>2385 Executive Center Dr.</u>	<u>Boca Raton FL 33431</u>
			<u>Reinstated</u>
			<u>2008-2010</u>
			<u>MPL</u>

11. E-mail Address: Alan@AMTInsuranceGroup.com

(To be used for future annual report notifications)

12. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in Chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 608.406, F.S., and that all fees owed by the limited liability company have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

Signature of

Managing Member/Manager

[Signature]

Date 2-24-10

Daytime Phone # 561 981-2591

Typed or printed name of signing Managing Member/Manager