

12/28/2017

L15000 197605

Division of Corporations

Florida Department of State
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To: Division of Corporations
Fax Number : (850)617-6383

From: atzanciatos@gunster.com
Account Name : GUNSTER, YOKLEY & STEWART, P.A.
Account Number : 076117000420
Phone : (561)650-0728
Fax Number : (561)671-2527

LLC DISSOLUTION OR WITHDRAWAL
HCB INSURANCE AGENCY, LLC

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FLORIDA DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

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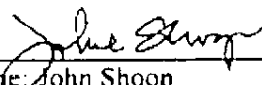
**ARTICLES OF DISSOLUTION
FOR A
FLORIDA LIMITED LIABILITY COMPANY**

HCB INSURANCE AGENCY, LLC

Pursuant to Sections 605.0701 and 605.0707 of the Florida Revised Limited Liability Company Act (the "Act"), the undersigned hereby submits these Articles of Dissolution to the Florida Department of State:

1. The name of the limited liability company is HCB INSURANCE AGENCY, LLC (the "Company").
2. The Articles of Organization were filed with the Florida Department of State on September 2, 2015 and assigned Document Number L15000147605.
3. These Articles of Dissolution shall be effective at 11:59 p.m. on December 31, 2017.
4. Pursuant to Section 605.0701 of the Act, dissolution was authorized on December 27, 2017 by the Joint Written Consent of the manager and sole member of the Company.

IN WITNESS WHEREOF, the undersigned hereby executes these Articles of Dissolution as of the 27th day of December, 2017.

By: 
Name: John Shoop
Title: Manager

17 DEC 28 AM 7:58
DEPARTMENT OF STATE
PALM BEACH, FLORIDA

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**NOTICE OF DISSOLUTION
FOR
FLORIDA LIMITED LIABILITY COMPANY**

This Notice of Limited Liability Company Dissolution is submitted by the dissolving limited liability company named below for resolution of payment of unknown claims against this limited liability company as provided in Section 605.07125 Florida Statutes.

Name of Limited Liability Company: HCB Insurance Agency, LLC.

Document Number of Limited Liability Company: L15000147605.

Date of Dissolution: December 31, 2017.

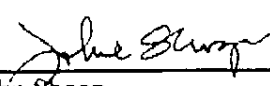
Description of Information that must be included in a written claim: The information that must be included in a claim submitted pursuant to this Notice shall be as follows:

- (a) Name, address and telephone number of claimant.
- (b) Amount of claim, including, if applicable, principal, interest, penalties or other fees or charges.
- (c) A statement of the basis for the claim.
- (d) A copy of any and all writings evidencing the claim or upon which the claim is based. (e) A statement of whether or not the claimant has other claims against the company or its managers, officers, agents or representatives, in their capacities as such, and, if the claimant states that the claimant has other claims, a statement of whether or not such other claims are being submitted pursuant to this Notice, or if such other claims will not be so submitted, a statement as to the reason why.

Mailing address where claims can be sent: A claim submitted pursuant to this Notice shall be mailed by certified or registered mail, return receipt requested, postage prepaid, to the following party: HCB Insurance Agency, LLC, 200 S. Indian River Drive, STE 101, Ft. Pierce, FL 34950

A claim against HCB Insurance Agency, LLC will be barred unless a proceeding to enforce the claim is commenced within 4 years after the filing of this notice.

HCB INSURANCE AGENCY, LLC


John Shoop
Manager

12 DEC 28 AM 7:52
CLERK OF STATE
TALLAHASSEE, FLORIDA

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