

L17000 157 795

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

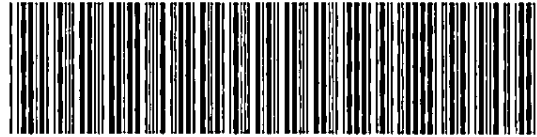
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

MAR 22 2019  
T. LEMIEUX

## COVER LETTER

**TO: Registration Section  
Division of Corporations**

SUBJECT: Health Plus Healthcare LLC  
Name of Limited Liability Company

The enclosed Articles of Amendment and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Robert Calhoun

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Name of Person

Health Plus Healthcare LLC

---

Firm/Company

13155 sw 134 st suite 223

---

Address

Miami, FL 33186

City/State and Zip Code \_\_\_\_\_

2000robert@gmail.com

E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Robert Calhoun                      786            228-9926  
\_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_  
Name of Person                  Area Code                  Daytime Telephone Number

Enclosed is a check for the following amount:

- ☒ \$25.00 Filing Fee      ☐ \$30.00 Filing Fee & Certificate of Status      ☐ \$55.00 Filing Fee & Certified Copy (additional copy is enclosed)      ☐ \$60.00 Filing Fee, Certificate of Status & Certified Copy (additional copy is enclosed)

**MAILING ADDRESS:**  
Registration Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**STREET/COURIER ADDRESS:**  
Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

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If amending Authorized Person(s) authorized to manage, enter the title, name, and address of each person being added or removed from our records:

MGR = Manager

AMBR = Authorized Member

<u>Title</u>	<u>Name</u>	<u>Address</u>	<u>Type of Action</u>
_____	_____	_____	<input type="checkbox"/> Add
		_____	<input type="checkbox"/> Remove
		_____	<input type="checkbox"/> Change
_____	_____	_____	<input type="checkbox"/> Add
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		_____	<input type="checkbox"/> Remove
		_____	<input type="checkbox"/> Change

[illegible]

E. Effective date, if other than the date of filing: \_\_\_\_\_ (optional)

**Note:** If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

Dated 3/1/19

Robert Calhoun

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**Filing Fee: \$25.00**