FLEASE READ ALL INSTRUCTIONS BEFORE COMPLETINGTHIS FORM

MITĖD LIABILITY
COMPANY
REINSTATEMENT

nature of authorized representative/member



FLORIDA DEPARTMENT OF STATE Secretary of State

DIVISION OF CORPORATIONS

ţst	OF STATE ATION
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JCUMENT# Company's Name				08/1	500359808816 08/10/2001042001 **60.00		
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Principal Office Address - No P.O. Box # 3. Mailing Office Address				\dashv	CR2E041 (1/14)		
38 - LOS 0/05 Blin 333 6/00 alos Blud				4. State/Cou	4. State/Country of Formation		
,Apt ≖,	etc	Suite, Apt			anized or Qualified siness in Florida		
& State	Zande.	dab Fl. Flo	and a	6 FEI Num		Applied For	
33c	Country	Δ $\frac{1}{3^333}$	Country SA	7. CERTIFICATE	OF STATUS DESIRED 55.00 Addition a config	tional Fee required icate of status	
lamu.	8. Nam	e and Address of Current R	egistered Agont	_			
<u>)Or</u>	Jid Ant	zbi	<u></u>				
treel Addres 333	is (P.O. Box Number is Not	Acceptable) Suite,					
pt # Etc		<u> </u>	·				
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I. being			ted liability company, am familiar with and a	accept the obligation	ons of Chapter 605, F.S.		
gnature of egistered Agent REGISTERED AGENT MUST SIGN					Date 18131 20 .		
Names	and Street Addresses of A	uthorized Representatives/Man	agers				
itles	Name of Authorized Representatives/ Managers		Street Address of Each Authorized Representative/ Manager		City / State / Zip		
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tify that i 5.0012, F all have t	when filing this reinstater F.S., and that all fees owi	ment application the reason fo ed by the limited liability comp f made under oath, I am awar	e receiver or trustee empowered to executor dissolution has been eliminated, the liminary have been paid. The information indice that false information submitted in a do	ute this application nited liability comp licated on this app	any name satisfies the requirement lication is true and accurate, and r	nt of section my signature	