

MD6000004425

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐

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☐

WAIT

☐

MAIL

(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer.

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OCT 27 2023

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10/27

FILED

2023 OCT 27 PM 12:29

SECRETARY OF STATE
JULIA M. HARRIS, Esq.

COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: MEDICARE ADVANTAGE ADVISORS, LLC

Name of Foreign Limited Liability Company

Dear Sir or Madam:

The enclosed application, certificate and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

ALYSSA DAVIS

Name of Person

AMERILIFE

Firm/Company

2650 MCCORMICK DR 200S

Address

CLEARWATER, FL 33759

City/State and Zip Code

ENTITY@AMERILIFE.COM

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

For further information concerning this matter, please call:

ALYSSA DAVIS _____ at (727) 726-0726
Name of Person Area Code & Daytime Telephone Number

Mailing Address:

Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Street Address:

Registration Section
Division of Corporations
The Centre of Tallahassee
2415 N. Monroe Street, Suite 810
Tallahassee, FL 32303

Enclosed is a check for the following amount:

☒ \$25 Filing Fee ☐ \$30 Filing Fee & Certificate of Status ☐ \$55 Filing Fee & Certified Copy ☐ \$60 Filing Fee, Certificate of Status & Certified Copy

**APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY TO FILE
AMENDMENT TO CERTIFICATE OF AUTHORITY TO TRANSACT
BUSINESS IN FLORIDA**

SECTION I (1-4 must be completed)

1. Name of limited liability Company as it appears on the records of the Florida Department of
State: MEDICARE ADVANTAGE ADVISORS, LLC

Enter new principal office address, if applicable: _____

(Principal office address
MUST BE A STREET ADDRESS)

Enter new mailing address, if applicable: _____

(Mailing address
MAY BE A POST OFFICE BOX)

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2023 OCT 27 PM 12:29
SECRETARY OF STATE

2. The Florida document number of this limited liability company is: M06000004425

3. Jurisdiction of its organization: DELAWARE

4. Date authorized to do business in Florida: 8/9/2004

SECTION II (5-9 complete only the applicable changes)

5. New name of the limited liability company: FRONTIER INSURANCE DISTRIBUTION, LLC
(must contain "Limited Liability Company," "L.L.C.," or "LLC.")

(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida and attach a copy of the written consent of the managers or managing members adopting the alternate name. The alternate name must contain "Limited Liability Company," "L.L.C." or "LLC.")

6. If amending the registered agent and/or registered officer address on our records, enter the name of the new registered agent and/or the new registered office address here:

Name of New Registered Agent: _____

New Registered Office Address: _____

Enter Florida Street Address

_____, Florida _____
City Zip Code

New Registered Agent's Signature, if changing Registered Agent:

I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 605, F.S. Or, if this document is being filed to merely reflect a change in the registered office address, I hereby confirm that the limited liability company has been notified in writing of this change.

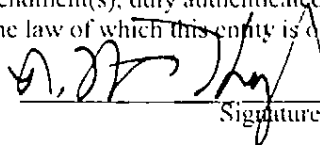
If Changing Registered Agent, Signature of New Registered Agent

7. If the amendment changes the jurisdiction of organization, indicate new jurisdiction:

8. If the amendment changes person, title or capacity in accordance with 605.0902 (1)(e), indicate that change:

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

9. Attached is a certificate, if required: no more than 90 days old, evidencing the aforementioned amendment(s), duly authenticated by the official having custody of records in the jurisdiction under the law of which this entity is organized.



 Signature of the authorized representative

R. NATHAN HIGHTOWER

 Typed or printed name of signee

Filing Fee: \$25.00


Delaware

The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF
DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT
COPY OF THE CERTIFICATE OF AMENDMENT OF "MEDICARE ADVANTAGE
ADVISORS, LLC", CHANGING ITS NAME FROM "MEDICARE ADVANTAGE
ADVISORS, LLC" TO "FRONTIER INSURANCE DISTRIBUTION, LLC", FILED
IN THIS OFFICE ON THE TWENTY-SIXTH DAY OF JULY, A.D. 2023, AT
1:30 O'CLOCK P.M.




Jeffrey W. Bullock, Secretary of State

4198737 8100
SR# 20233088319

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 203834338
Date: 07-26-23

**STATE OF DELAWARE
CERTIFICATE OF AMENDMENT**

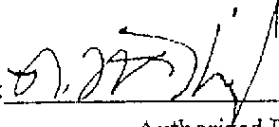
1. Name of Limited Liability Company: Medicare Advantage
Advisors, LLC

2. The Certificate of Formation of the limited liability company is hereby amended
as follows:

The existing Paragraph 1 is hereby deleted, and the
following is hereby inserted in lieu thereof

"1 The name of the limited liability company is
Frontier Insurance Distribution, LLC"

IN WITNESS WHEREOF, the undersigned have executed this Certificate on
the 21st day of July, A.D. 2023.

By: 
Authorized Person(s)

Name: R. Nathan Hightower
Print or Type