PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

18 FEB -1 PM 2:44

700308717797

CR2E041 (1/14)

DOCUMENT # M08000002626

1. Limited Liability Company's Name
HEALTHHELP, LLC

2. Principal Office Address - No P.O. Box #		3. Mailing Office Address	
16945 Northchase Dr			
Suite, Apt. #, etc		Suite, Apt. #, etc.	
1300			
City & State		City & State	
Houston, TX			
Zip	Country	Zip	Country
77060			

4. State/Country of Formation
Delaware

5. Date Organized or Qualified To Do Business in Florida
06/04/2008

6. FEI Number
20-0948131
☐ 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
C T CORPORATION SYSTEM

Street Address (P.O. Box Number is Not Acceptable)
1200 SOUTH PINE ISLAND ROAD

Suite, Apt. #, Etc.

City	State	Zip Code
Plantation	FL	33324

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent Angel Shearer Date 1/31/18
REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Authorized Representatives/Managers

Titles	Name of Authorized Representatives/ Managers	Street Address of Each Authorized Representative/ Manager	City / State / Zip
CEO	Cherrill Farnsworth	16945 Northchase Dr	Houston TX 77060
EVP	Sumit Sachdeva	16945 Northchase Dr	Houston TX 77060

REINSTATEMENT
2017-2018

11. E-mail Address accounting@healthhelp.com
(To be used for future annual report notifications)

12. I certify that I am an authorized representative/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 605.0012, 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. I am aware that false information submitted to the Department of State constitutes a third degree felony as provided in s. 817.155, F.S.

Signature of Authorized Representative/Manager Cherrill Farnsworth Date 1-29-2018 Daytime Phone # 281-447-7000

Typed or printed name of signing Authorized Representative/Manager Cherrill Farnsworth

CT Corp.

3458 Lakeshore Drive, Tallahassee, FL 32312
850-656-4724

Date: 2/1/2018

Acc#I20160000072

Name:	Healthhelp, LLC
Document #:	M08000002626
Order #:	10793590

Certified Copy of Arts & Amend:	☐			
Plain Copy:	☐			
Certificate of Good Standing:	☐			
	☐			
Apostille/Notarial Certification:	☐		Country of Destination:	
			Number of Certs:	

Filing:	Certified:
	Plain:
	COGS:

Availability _____
Document _____
Examiner _____
Updater _____
Verifier _____
W.P. Verifier _____
Ref# _____

Amount: $ ~~407.50~~
377.50

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DIVISION OF CORPORATIONS
TALLAHASSEE, FLORIDA

Thank you!