

M08 000 005 440

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

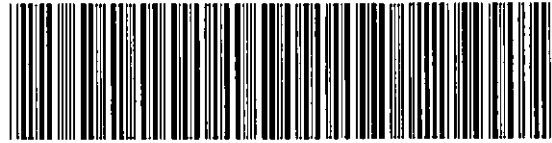
(Business Entity Name)

(Document Number)

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

Special Instructions to Filing Officer.

Office Use Only



300442602293

01/16/25--01004--008 \*\*25.00

FILED  
25 JAN 16 PM 5:28  
RECEIVED  
2025 JAN 16 AM 11:17  
SIXTH FLOOR  
TOLSON BLDG  
WASHINGTON, DC 20535

## COVER LETTER

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** Smart Cremation of Florida, 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:

Tim Birch

Name of Person

NorthStar Memorial Group

Firm/Company

1900 St James Place, Suite 300

Address

Houston, TX 77056

City/State and Zip Code

Tim.Birch@nsmg.com

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

For further information concerning this matter, please call:

Tim Birch

at ( 203 ) 559-4911

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

CR2E055 (9/15)

**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: Smart Cremation of Florida, 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)

2. The Florida document number of this limited liability company is: M08000005440

3. Jurisdiction of its organization: Delaware

4. Date authorized to do business in Florida: 12/12/2008

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

5. New name of the limited liability company: \_\_\_\_\_  
(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

\_\_\_\_\_, 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

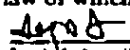
7. If the amendment changes the jurisdiction of organization, indicate new jurisdiction:

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

Change of President/CFO

Title/Capacity	Name	Address	Type of Action
President/ CFO	Justin Clark		<input type="checkbox"/> Add
		1900 St. James Place, Suite 300 Houston, TX 77056	<input checked="" type="checkbox"/> Remove
President/ CFO	John Renfro	1900 St. James Place, Suite 300 Houston, TX 77056	<input checked="" type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<input type="checkbox"/> Add
			<input type="checkbox"/> Remove
			<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.

  
Timothy A. Birch Jan 15, 2025 10:11 PST

Signature of the authorized representative

Timothy A. Birch

Typed or printed name of signer

Filing Fee: \$25.00






# 2025 01 15 Sunbiz SMart - FL Change of Officer - remove JC add JR

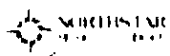
Final Audit Report

2025-01-15

Created:	2025-01-15
By:	Monica Gutierrez (GutierrezM@nsmg.com)
Status:	Signed
Transaction ID:	CBUCHBCAABAAnOp1uHCdLJO2BnVBVV2Acc0r2Bn9t0C2

## "2025 01 15 Sunbiz SMart - FL Change of Officer - remove JC add JR" History

-  Document created by Monica Gutierrez (GutierrezM@nsmg.com)  
2025-01-15 - 10:06:32 PM GMT
-  Document emailed to Timothy Birch (tim.birch@nsmg.com) for signature  
2025-01-15 - 10:06:07 PM GMT
-  Email viewed by Timothy Birch (tim.birch@nsmg.com)  
2025-01-15 - 10:13:15 PM GMT
-  Document e-signed by Timothy Birch (tim.birch@nsmg.com)  
Signature Date: 2025-01-15 - 10:13:44 PM GMT - Time Source: server
-  Agreement completed.  
2025-01-15 - 10:13:44 PM GMT



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January 15, 2025

Hi Brian. ,

Please remember you are **required** to use any available PTO while out on leave. We can spread out accrued PTO to assist in covering the cost of your benefits, please coordinate time off with your RDO.

If you have exhausted all your PTO, we will need to collect the premiums to ensure you and/or your dependents (if applicable) have no lapse in coverage. Please submit a check payable to Sequoia Care for the monthly amount of your benefits to the following address to the attention of Cheryl Kovalik, Payroll Manager:

**Sequoia Care  
PO Box 470724  
Broadview Hts, Ohio 44147  
Attn: Cheryl Kovalik, Payroll Manager**

If you have STD benefits from Sequoia Care and do file a claim - **please let us know the number of weeks, you will collect STD benefits.**

You are currently enrolled in the following:

**Current Benefits                      Premium per pay                      \*Monthly premium due 1<sup>st</sup> day of month**

Dental Employee only	5.80	11.60
SunLife LTD	2.88	5.76
AFLAC STD	15.60	31.20
Vision Employee only	.84	1.68
AFLAC whole life	15.51	31.02
AFLAC Accident	10.74	21.48
<b>TOTAL</b>	<b>\$ 51.37</b>	<b>\$ 102.74</b>

***Please sign & date this form and return to me within 10 days of receipt.***

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Print    Signature    Date

If you have any questions or concerns, please contact me directly.

*Lee Black*



Lee Black Human Resources Dept.  
phone: 330-946-4082