Florida Department of State
Division of Corporations
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To:
Division of Corporations
Fax Number : (850)617-6384

From:
Account Name : C T CORPORATION SYSTEM
Account Number : FCA000000023
Phone : (614)280-3338
Fax Number : (954)208-0845

Enter the email address for this business entity to be used for future annual report mailings. Enter only one email address please.

Email Address: _____

LIMITED LIABILITY REINSTATEMENT
GAELIC FINANCIAL SERVICES, L.L.C.

Certificate of Status	0
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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

CR2E041 (1/14)

DOCUMENT # M10000004817

1. Limited Liability Company's Name
GAELIC FINANCIAL SERVICES, L.L.C.

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
76 MERRION SQUARE	76 MERRION SQUARE
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: DUBLIN	City & State: DUBLIN
Zip: D02 NY76 Country: IRELAND	Zip: D02 NY76 Country: IRELAND

4. State/Country of Formation: Delaware

5. Date Organized or Qualified To Do Business in Florida: 11/01/2010

6. FEI Number: 98-0171588 ☐ Applied For ☐ Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐ $30.00 Additional Fee Required

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: PLANTATION State: FL Zip Code: 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: Chris Rickard Date: 11-28-16

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Author zed Representatives/Managers

Title	Name of Authorized Representative/ Manager	Street Address of Each Authorized Representative/ Manager	City / State / Zip
MR.	JOHN H. PROSSER	76 Merrion Sq, D02 76NY	Dublin, Ireland
			NOV 28 2016
	REINSTATEMENT		R. HUNT

11. E-mail Address: TRICHARDSON@ABBEYINTFINANCE
(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 605, 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 605.0112, 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: John H. Prosser Date: 24/11/2016 Daytime Phone #: 00353-1-6644090

Typed or printed name of signing Authorized Representative/Manager: JOHN H. PROSSER GENERAL MANAGER