Florida Department of State
Division of Corporations
Electronic Filing Cover Sheet

Note: Please print this page and use it as a cover sheet. Type the fax audit number (shown below) on the top and bottom of all pages of the document.

(((H16000290583 3)))

H16000290583ABC1

Note: DO NOT hit the REFRESH/RELOAD button on your browser from this page. Doing so will generate another cover sheet.

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
AXEL VERVOORDT USA, LLC

Certificate of Status	0
Certified Copy	0
Page Count	02
Estimated Charge	$238.75

Electronic Filing Menu Corporate Filing Menu Help

NOV 28 2016

R. HUNT

FILED

2016 NOV 28 PM 1:09

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # M14000001521

1. Limited Liability Company's Name
AXEL VERVOORDT USA, LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
170 PEQUOT AVENUE CT 06890	PO BOX 491
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: SOUTHPORT, CT	City & State: SOUTHPORT, CT
Zip: 06890 Country:	Zip: 06890 Country:

4. State/Country of Formation: New York

5. Date Organized or Qualified To Do Business in Florida: 03/06/2014

6. FEI Number: 01-0916996 ☐ 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: 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 _____ Date _____

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
AR-A	VAN SCHEVENSTEEN	STOKERIJSTRAAT 15-19	WIJNEGEM BELGIUM 2110

REINSTATEMENT NOV 28 2016

R. HUNT

11. E-mail Address: FRANCOIS.VANSCHEVENSTEEN@AXEL-VERVOORDT.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 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 605.0012, 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 _____ Date NOV 22nd 16 Daytime Phone # +32 3 355 3304

Typed or printed name of signing Authorized Representative/Manager VAN SCHEVENSTEEN