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Florida Department of State
Division of Corporations
Electronic Filing Cover Sheet

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To: Division of Corporations
Fax Number : (850)617-6383

From: Account Name : C I CORPORATION SYSTEM
Account Number : FCA000000023
Phone : (614)280-3338
Fax Number : (614)573-3996

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

Email Address: amills-handy@heatthequity.com

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DEPARTMENT OF STATE
DIVISION OF CORPORATIONS
TALLAHASSEE, FLORIDA

Foreign Limited Liability Company
HEALTHEQUITY PAYMENTS, LLC

Certificate of Status	0
Certified Copy	1
Page Count	04
Estimated Charge	\$155.00

SECRETARY OF STATE
TALLAHASSEE, FLA

2024 MAR -4 PM 3:49

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APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY FOR AUTHORIZATION TO TRANSACT BUSINESS IN FLORIDA

IN COMPLIANCE WITH SECTION 605.0602, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN LIMITED LIABILITY COMPANY TO TRANSACT BUSINESS IN THE STATE OF FLORIDA:

1. HealthEquity Payments, LLC
(Name of Foreign Limited Liability Company must include "Limited Liability Company," "L.L.C.," or "LLC")

If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida. The alternate name must include "Limited Liability Company," "L.L.C.," or "LLC."

2. Delaware 93-4650480
(Jurisdiction under the law of which foreign limited liability company is organized) (EIN number, if applicable)

4. Upon Filing
(Date first transacted business in Florida, if prior to registration.
(See sections 605.0603 & 605.0605, F.S., to determine penalty liability.)

5. 121 W Scenic Pointe Dr. 121 W Scenic Pointe Dr.
(Street Address of Principal Office) (Mailing Address)
Drapet, UT 84020 Drapet, UT 84020

7. Name and street address of Florida registered agent: (P.O. Box NOT acceptable)

Name: C.T Corporation System
Office Address: 1200 South Pine Island Road
Plantation, Florida 33324
(City) (Zip code)

Registered agent's acceptance:
Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this application, 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.

By: C.T Corporation System SEAN L. EMERICK, ASSISTANT SECRETARY
(Registered agent's signature)

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TALLAHASSEE, FL

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8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

<u>Title or Capacity:</u>	<u>Name and Address:</u>	<u>Title or Capacity:</u>	<u>Name and Address:</u>
<input type="checkbox"/> Manager	Name: <u>HealthEquity, Inc.</u>	<input type="checkbox"/> Manager	Name: <u>Morgen Weeks</u>
<input checked="" type="checkbox"/> Member	Address: <u>121 W Scenic Pointe Dr.</u>	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	<u>Draper, UT 84020</u>	<input checked="" type="checkbox"/> Authorized	<u>121 W Scenic Pointe Dr.</u>
Person	_____	Person	<u>Draper, UT 84020</u>
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

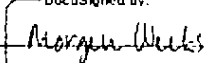
<input type="checkbox"/> Manager	Name: _____	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

<input type="checkbox"/> Manager	Name: _____	<input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Important Notice: Use an attachment to report more than six (6). The attachment will be imaged for reporting purposes only. Non-indexed individuals may be added to the index when filing your Florida Department of State Annual Report form.

9. Attached is a certificate of existence, no more than 90 days old, duly authenticated by the official having custody of records in the jurisdiction under the law of which it is organized. (If the certificate is in a foreign language, a translation of the certificate under oath of the translator must be submitted)

10. This document is executed in accordance with section 605.0203 (1) (b), Florida Statutes. I am aware that any false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.

DocuSigned by:

 4866F255FC5841A... Signature of an authorized person

Morgen Weeks

Delaware

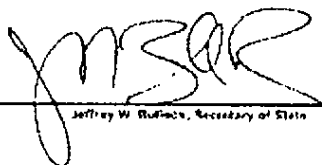
The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "HEALTHY EQUITY PAYMENTS, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-THIRD DAY OF JANUARY, A.D. 2024.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.




Jeffrey W. Bullock, Secretary of State