

ND8000010487

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

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(Business Entity Name)

(Document Number)

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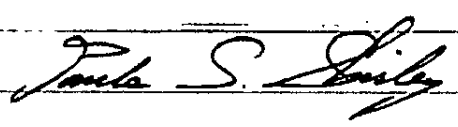
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|   |       |                  |                 |                                  |                 |  |  |
|---|-------|------------------|-----------------|----------------------------------|-----------------|--|--|
| STATE OF FLORIDA  |       | VOUCHER SCHEDULE |                 | DATE 11/07/2008                  |                 | S-W/Agency Voucher No.<br><b>D90-0027-2072</b><br><b>003702</b><br><b>\$</b> |  |
| OLO 680000  |       | JT-2             |                 |                                  |                 |  |  |
| DEPARTMENT AGENCY FOR HEALTH CARE ADMINISTRATION  |       |                  |                 |                                  |                 |  |  |
| SITE FINANCE AND ACCOUNTING-PRINTER ID.- R981   |       |                  |                 |                                  |                 |  |  |
| CFO ACCOUNT NUMBER  | CF    | OBJECT CODE      | TRANS CODE      | 25                               | TRANS CODE      | 45   |  |
| CFO ACCOUNT NAME  |       |                  |                 |                                  |                 |  |  |
| INVOICE   |       |                  | INCREASE AMOUNT |                                  | INCREASE AMOUNT |  |  |
| 68202003001-6870070000-10077700   |       | 1325             | 78.75           |                                  |                 |  |  |
| HEALTH CARE TRUST FUND/AHCA   |       |                  |                 |                                  |                 |  |  |
| CONTRACTED SERVICES   |       |                  |                 |                                  |                 |  |  |
| INV: HL CHOICE  | 78.75 |                  |                 |                                  |                 |  |  |
| 45101000132-4530010000-00010000   |       |                  |                 |                                  |                 | 78.75  |  |
| GENERAL REVENUE FUND  |       |                  |                 |                                  |                 |  |  |
| FEES  |       |                  |                 |                                  |                 |  |  |
| TRANSACTION TYPE: JOURNAL ADVICE  |       |                  | TOTAL           |                                  | TOTAL           |  |  |
|   |       |                  | 78.75           |                                  | 78.75           |  |  |
| I hereby certify that the above transactions are in accordance with the Florida Statutes and all applicable laws and rules of the State of Florida. |       |                  |                 | For State Comptroller's Use Only |                 |  |  |
| APPROVED:    |       |                  |                 | Time In                          |                 |  |  |
|   |       |                  |                 |                                  |                 | Audited By   |  |
| TITLE   |       |                  |                 |                                  |                 |  |  |

AGENCY COPY

## COVER LETTER

Department of State  
Division of Corporations  
P. O. Box 6327  
Tallahassee, FL 32314

**SUBJECT:** Florida Health Choices, Inc.

(**PROPOSED CORPORATE NAME – MUST INCLUDE SUFFIX**)

Enclosed is an original and one(1) copy of the Articles of Incorporation and a check for :

☐ \$70.00  
Filing Fee

☒ \$78.75  
Filing Fee &  
Certificate of  
Status

☐ \$78.75  
Filing Fee  
& Certified Copy

☐ \$87.50  
Filing Fee,  
Certified Copy  
& Certificate

**ADDITIONAL COPY REQUIRED**

**FROM:** Tom Warring

Name (Printed or typed)

2727 Mahan Drive, Mail Stop # 26

Address

Tallahassee, FL 32308

City, State & Zip

(850) 487-0640

Daytime Telephone number

**NOTE: Please provide the original and one copy of the articles.**

**ARTICLES OF INCORPORATION**  
In Compliance with Chapter 617, F.S., (Not for Profit)

**ARTICLE I NAME**

The name of the corporation shall be:

Florida Health Choices, Inc.

**ARTICLE II PRINCIPAL OFFICE**

The principal street address and mailing address, if different is:

2727 Mahan Drive  
Building 1, Room 303  
Tallahassee, FL 32308

**ARTICLE III PURPOSE**

The purpose for which the corporation is organized is:

In accordance with Chapter 2008-32, laws of Florida, the purpose of this corporation is to establish, oversee and maintain the Florida Health Choices Program, a centralized market for the sale and purchase of products that enable individuals to pay for health care.

**ARTICLE IV MANNER OF ELECTION**

The manner in which the directors are elected or appointed:

Three ex officio directors are established in law to include the Secretary of the Agency for Health Care Administration (or designee), the Secretary of the Department of Management Services (or designee) and the Commissioner of the Office of Insurance Regulation (or designee). The law requires 12 additional voting directors, four each appointed by the Governor of Florida, Speaker of the Florida House of Representatives and the President of the Florida Senate.

**ARTICLE V INITIAL DIRECTORS AND/OR OFFICERS**

List name(s), address(es) and specific title(s):

To be determined upon appointment.

**ARTICLE VI INITIAL REGISTERED AGENT AND STREET ADDRESS**

The name and Florida street address (P.O. Box NOT acceptable) of the registered agent is:

Tom Warring  
2727 Mahan Drive, Building 1, Room 303  
Tallahassee, FL 32308

**ARTICLE VII INCORPORATOR**

The name and address of the Incorporator is:

Tom Warring  
2727 Mahan Drive, Building 1, Room 303  
Tallahassee, FL 32308

\*\*\*\*\*  
*Having been named as registered agent to accept service of process for the above stated corporation at the place designated in this certificate, I am familiar with and accept the appointment as registered agent and agree to act in this capacity.*

\_\_\_\_\_  
Signature/Registered Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/Incorporator

\_\_\_\_\_  
Date

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