


2004 FOR PROFIT CORPORATION ANNUAL REPORT

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DOCUMENT # P02000054340 1. Entity Name ASSURANCE CARE MANAGEMENT, INC.						FILED 04 OCT -8 PM 12:24 SECRETARY OF STATE TALLAHASSEE, FLORIDA	
Principal Place of Business 5890 SW 8TH STREET MIAMI, FL 33144				Mailing Address 5890 SW 8TH STREET MIAMI, FL 33144			
2. Principal Place of Business Suite, Apt. #, etc.				3. Mailing Address Suite, Apt. #, etc.			
City & State				City & State			
Zip		Country		Zip		Country	
6. Name and Address of Current Registered Agent VALDES, GLADYS 5890 SW 8TH STREET MIAMI, FL 33144				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code			
8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.							
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) <small>Signature, typed or printed name of registered agent and title if applicable.</small>							
FILE NOW!!! FEE IS \$550.00 Due by September 8, 2004				9. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/> \$5.00 May Be Added to Fees			
10. OFFICERS AND DIRECTORS				11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11			
TITLE NAME STREET ADDRESS CITY-ST-ZIP P VALDES, GLADYS I 5890 SW 8TH STREET MIAMI, FL 33144				TITLE NAME STREET ADDRESS CITY-ST-ZIP 000041709650 10/08/04--01029--004 **150.00			
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12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed; or on an attachment with an address, with all other like empowered.							
SIGNATURE: <i>Gladys Valdes</i> 10/05/04 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>							

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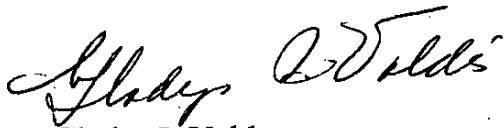
Assurance Care Management, Inc.
5890 SW 8th ST
Miami, FL 33144
Ph: (305) 266-0284

October 04, 2004

To Whom It May Concern:

**We did not receive notice of this annual report being due by May 1,
pursuant to 607.193(1)(b), Florida Statutes.**

**If you have any question, please fee free to contact me.
Thank you,**


Gladys I. Valdes