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	Mailing Address
5890 SW 8TH STREET MIAMI, FL 33144	5890 SW 8TH STREET MIAMI, FL 33144

09212004 Chg-P CR2E034 (10/03)

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number: 03-0467573 — Applied For / Not Applicable

5. Certificate of Status Desired ☐ — **$8.75** Additional Fee Required

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 ______________________ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $550.00 *
Due by September 8, 2004

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS

TITLE	P	☐ Delete
NAME	VALDES, GLADYS I	
STREET ADDRESS	5890 SW 8TH STREET	
CITY-ST-ZIP	MIAMI, FL 33144	
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP	000041709850 10/08/04--01029--004 **150.00	☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
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TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition
TITLE / NAME / STREET ADDRESS / CITY-ST-ZIP		☐ Change ☐ Addition

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: X Gladys I. Valdes 10/05/04
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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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