

Signature: LEGNA CHACON P

Electronic Signature of Signing Officer, Director, Incorporator or Authorized Representative

Notice of Corporate Dissolution

This notice is submitted by the dissolved corporation named below for resolution of payment of unknown claims against this corporation as provided in s. 607.1407, F.S.

Name of Corporation:

L CHACON HEALTH CARE CORP

Date of dissolution will be the date the dissolution is filed with the Department of State or as specified in the Articles of Dissolution.

Description of information that must be included in a claim:

VOLUNTARY DISSOLUTION, NO LONGER NEED TO CORPORATION.

Mailing address where claims can be sent:

4717 SW 135TH CT
MIAMI, FL 33175

A claim against the above named corporation will be barred unless a proceeding to enforce the claim is commenced within 4 years after the filing of this notice.

I submit this document and affirm that the facts stated herein are true. 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 section 817.155, Florida Statutes.

Signature: LEGNA CHACON

Electronic Signature of the Person Filing