

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER SEPTEMBER 15, 1999.  
AMOUNT DUE ON OR BEFORE 09/15/99: \$550 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$750).

**FILED**  
**Aug 19, 1999 8:00 am**  
**Secretary of State**

08-19-1999 90012 014 \*\*\*150.00

**PROFIT  
CORPORATION  
ANNUAL REPORT  
1999**



FLORIDA DEPARTMENT OF STATE  
**Katherine Harris**  
Secretary of State  
DIVISION OF CORPORATIONS

**DOCUMENT # P97000083778**

1. Corporation Name

**MEDCARE PLUS, INC.**

Principal Place of Business

1420 CHESAPEAKE DR  
ODESSA FL 33556  
US

Mailing Address

1420 CHESAPEAKE DR  
ODESSA FL 33556  
US

DO NOT WRITE IN THIS SPACE

3. Date Incorporated or Qualified

**09/26/1997**

4. FEI Number

**59-3474296**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75** Additional  
Fee Required

6. Election Campaign Financing  
Trust Fund Contribution ☐

**\$5.00** May Be  
Added to Fees

8. This corporation owes the current year  
Intangible Personal Property. ☐ Yes ☐ No

2. Principal Place of Business

21

Suite, Apt. #, etc.

22 City & State

23

Zip

Country

24

2a. Mailing Address

26

Suite, Apt. #, etc.

27 City & State

28

Zip

Country

29

30

9. Name and Address of Current Registered Agent

**KEITH, KENNETH A  
1202 MONTE LAKE DR.  
VALRICO FL 33594**

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

**FL**

85 Zip Code

11. Pursuant to the provisions of sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, section 607.0505, Florida Statutes.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

TITLE ☐ DELETE  
NAME **D RODRIGUEZ, DENNIS E**  
STREET ADDRESS **1420 CHESAPEAKE DR**  
CITY-ST-ZIP **ODESSA FL 33556**

TITLE ☐ DELETE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

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CITY-ST-ZIP

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STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

1.1 TITLE ☐ Change ☐ Addition  
1.2 NAME  
1.3 STREET ADDRESS  
1.4 CITY-ST-ZIP

2.1 TITLE ☐ Change ☐ Addition  
2.2 NAME  
2.3 STREET ADDRESS  
2.4 CITY-ST-ZIP

3.1 TITLE ☐ Change ☐ Addition  
3.2 NAME  
3.3 STREET ADDRESS  
3.4 CITY-ST-ZIP

4.1 TITLE ☐ Change ☐ Addition  
4.2 NAME  
4.3 STREET ADDRESS  
4.4 CITY-ST-ZIP

5.1 TITLE ☐ Change ☐ Addition  
5.2 NAME  
5.3 STREET ADDRESS  
5.4 CITY-ST-ZIP

6.1 TITLE ☐ Change ☐ Addition  
6.2 NAME  
6.3 STREET ADDRESS  
6.4 CITY-ST-ZIP

14. 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 annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (5/99)

0087663

**JUNCO & COMPANY**

CERTIFIED PUBLIC ACCOUNTANTS

MEMBER:

AMERICAN INSTITUTE OF  
CERTIFIED PUBLIC ACCOUNTANTS

FLORIDA INSTITUTE OF  
CERTIFIED PUBLIC ACCOUNTANTS

5041 WEST CYPRESS STREET, SUITE 100  
TAMPA, FLORIDA 33607

TELEPHONE:  
(813) 287-1519

FACSIMILE:  
(813) 287-8468

P97000083778  
608061-9002-14

August 11, 1999

Katherine Harris  
Secretary of State  
Division of Corporations  
Annual Reports Filings  
P.O. Box 1500  
Tallahassee, FL 32302-1500

**RE: Medicare Plus Inc.**  
**Doc. No.: P97000083778**  
**FEI No.: 59-3474296**

Dear Ms. Harris:

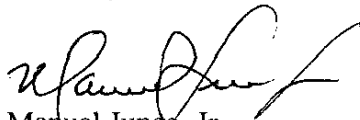
Our client states that he submitted the \$150.00 due to the state by money order with the first notice on timely bases.

Apparently the form and the \$150.00 were lost in the mail. I gather this assumption by your second notice.

Please accept this reasonable cause and the \$150.00 money order as a timely payment of the annual filing fee.

If you have any questions, please contact me.

Sincerely,



Manuel Junco, Jr.  
Certified Public Accountant

MJ:dh

Enclosure