PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1 of 2

APPLICATION FOR ~~REINSTATEMENT~~

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

FILED
00 OCT 24 PM 12:50
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P98000104116**

1. Corporation Name

HEALTHCARE RISK MANAGEMENT GROUP, INC.

Principal Place of Business	Mailing Address
~~1010 MCDONALD ST~~ 206 E. 9th Ave.	~~1010 MCDONALD ST~~ 206 E. 9th Ave.
MT DORA FL 32757	MT DORA FL 32757

2000 UBR

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 12/14/1998

5. FEI Number: 59-3477323 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee required for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
D	~~MANGLES~~, LINDA S	~~1010 MCDONALD ST~~	MT DORA FL 32757
	MANGELS	206 E. 9th Ave	
			900003483679--2 -12/01/00--01087--014 ****150.00 ****150.00

8. Name and Address of Current Registered Agent

MANGLES, LINDA S
1010 MCDONALD ST
MT DORA FL 32757

MANGELS, Linda S
206 E 9th Ave.
32757

9. Name and Address of New Registered Agent

Name
Street Address (P.O. Box Number is Not Acceptable)
Suite, Apt. #, Etc.
City | State: FL | Zip Code

CR2E040 (8/00)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of Registered Agent: I SIGNATURE REQUIRED — REGISTERED AGENT MUST SIGN — Date: 10/15/00

11. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE: SIGNATURE REQUIRED — SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date: 10/15/00 — Daytime Phone #: 352-735-2255

0012092 AF

HealthCare Risk Management Group, Inc.

206 E. Ninth Avenue • Mount Dora, Florida 32757
(352) 735-2255 • Fax (352) 735-7692

P98000104116

The name Spelling and address are incorrect. I received no renewal forms. My post man brought this to me because he knows me. Please accept this renewal check that I am sending as requested after my call to you on 10/15/00.

Thank you for your help. Please Correct name Spelling and address.

Debbie