

LOT 000014852

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP WAIT MAIL

(Business Entity Name)

(Document Number)

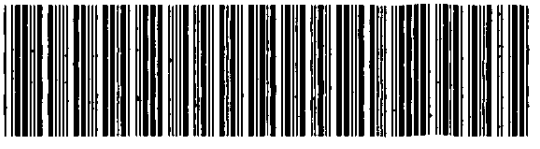
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COVER LETTER

TO: Registration Section
Division of Corporations

SUBJECT: CARE MEDICAL PLAN LLC.
(Name of Limited Liability Company)

The enclosed member, managing member or manager resignation and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to:

ENRIQUE ZAMORA
(Contact Person)

CARE MEDICAL PLAN LLC.
(Firm/Company)

3520 WEST 18 AVE SUITE 115
(Address)

HIALEAH FL 33012
(City/State and Zip Code)

For further information concerning this matter, please call:

ENRIQUE ZAMORA at (305) 796-3544
(Name of Contact Person) (Area Code & Daytime Telephone Number)

Enclosed please find a check made payable to the Florida Department of State for:

\$25 Filing Fee

\$55 Filing Fee &
Certified Copy

STREET/COURIER ADDRESS:
Registration Section
Division of Corporations
Clifton Building
2661 Executive Center Circle
Tallahassee, Florida 32301

MAILING ADDRESS:
Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314



FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS

**RESIGNATION OF MEMBER, MANAGING MEMBER OR MANAGER
FROM FLORIDA OR FOREIGN LIMITED LIABILITY COMPANY**

1. The name of the limited liability company as it appears on the records of the Florida Department of State is: CARE MEDICAL PLAN LLC.

2. This limited liability company was organized under the laws of:
FLORIDA

3. The Florida document/registration number of this limited liability company is:
L07000014852

4. I, ENRIQUE ZAMORA, hereby resign as a PD
(Print Name of Person Resigning) *(Print Title)*

of this limited liability company and affirm the limited liability company has been notified of my resignation in writing.

Signature of Resigning Member, Managing Member or Manager

Filing Fee: \$25.00 (Required)
Certified Copy: \$30.00 (Optional)

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DIVISION OF CORPORATIONS
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