



State of Rhode Island  
**Department of State - Business Services Division**

**Statement of Change of Agent**  
 DOMESTIC or FOREIGN Limited Liability Company

→ Filing Fee: \$20.00

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 R.I. DEPT. OF STATE  
 BUS SVCS DIV  
 2023 MAY -2 P 1:16

Pursuant to the provisions of RIGL 7-16-11 the undersigned limited liability company submits the following statement for the purpose of changing its resident agent in the State of Rhode Island:

|   |  |   |                    |
|---|--|---|--------------------|
| 1. Entity ID Number<br>000871747  |  | 2. Exact Name of the Limited Liability Company<br>Elsmere Insurance Agency, LLC |                    |
| 3. The address of the resident office as <b>PRESENTLY</b> shown in the records on file with the RI Department of State:   |  |   |                    |
| Street Address 222 JEFFERSON BOULEVARD, SUITE 200   |  |   |                    |
| City/Town WARWICK   |  | State RHODE ISLAND  | Zip 02888          |
| 4. The name of the resident agent as <b>PRESENTLY</b> shown in the records on file with the RI Department of State:<br>CORPORATION SERVICE COMPANY  |  |   |                    |
| 5. The address of the <b>NEW</b> resident office is:  |  |   |                    |
| Street Address (NOT a P.O. Box) 450 Veterans Memorial Parkway, Suite 7A   |  |   |                    |
| City/Town East Providence   |  | State RHODE ISLAND  | Zip 02914          |
| 6. The name of the <b>NEW</b> resident agent is:<br>C T Corporation System  |  |   |                    |
| 7. Date when this Statement of Change of Resident Agent will be effective: <b>CHECK ONE BOX ONLY</b>  |  |   |                    |
| <input checked="" type="checkbox"/> Date received (Upon filing)   |  |   |                    |
| <input type="checkbox"/> Later effective date (Date must be no more than 90 days from the date of filing) _____   |  |   |                    |
| Under penalty of perjury, I declare and affirm that I have examined this Statement of Change of Resident Agent by the Limited Liability Company, and that all statements contained herein are true and correct. |  |   |                    |
| Name of Authorized Person of the Limited Liability Company<br>STEPHANIE HENCZ, MANAGER  |  |   | Date<br>03/07/2023 |
| Signature of Authorized Person of the Limited Liability Company<br><i>Stephanie Hencz</i>   |  |   |                    |

**MAIL TO:**  
 Division of Business Services  
 148 W. River Street, Providence, Rhode Island 02904-2615  
 Phone: (401) 222-3040  
 Website: www.sos.ri.gov

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