



**CITY OF SOMERVILLE**  
Commonwealth of Massachusetts  
93 Highland Avenue  
Somerville, MA 02143  
(617) 625-6600

### Application to Renew Lodging House License

**WALNUT HILL PROPERTIES CORP**  
PO BOX 53053  
MEDFORD MA 02153

License #: BL15-000110  
File #: 15-122  
Fee: 605

Review and update the information below. If you have workers compensation insurance, attach proof showing the insurer and policy number. Then sign the Acknowledgment and return this form with your fee to the City Clerk's Office.

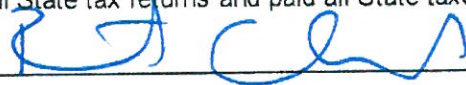
INFORMATION ON FILE:	CHANGES: (Note below or explain on a separate sheet)
Business/DBA Name: THETA CHI Business Location: 100 PACKARD AVE Business Phone: 781-391-5300	
License Holder: WALNUT HILL PROPERTIES CORP <del>PO BOX 53053</del> MEDFORD MA <del>02153</del>	47 Winthrop St Medford MA 02155
Mailing Address: WALNUT HILL PROPERTIES CORP <del>PO BOX 53053</del> MEDFORD MA <del>02153</del>	as above
Business Type: Corporation LINDA SNYDER THOMAS MCGURTY ROBERT CHIHADÉ	
FID: 043419100	
Emergency Contact: ROBERT CHIHADÉ Phone: 781-391-5300	
Name of lodging house: Not yet provided. Location of lodging house: 100 PACKARD AVE # of Residents: 11	

I hereby certify under the penalties of perjury that the following is true:

-All information shown above is true and accurate.

-Any changes above are subject to the approval of the BOARD OF ALDERMEN.

-I have filed all State tax returns and paid all State taxes required by law for this business.

Signature:  Date: 7/29/15

Printed Name: Robert O. Chihade Phone: 781-391-5300

### APPLICATION FOR A LODGING HOUSE LICENSE

Nonrefundable Application Fee \$550.00

Date 7/1/15

FOR CITY CLERK'S OFFICE ONLY
Date Recorded _____
Amount Paid _____

2015 JUL 29 A 10:46  
 CITY CLERK'S OFFICE  
 SOMERVILLE, MA

New Application

Renewing Application with Additions or Changes

Renewing Application with NO Additions or Changes

Walnut Hill Properties Corp, 100 PACKARD AVE

Business (DBA) Name: dba Theta Chi Phone: 781-391-5300

Applicant's Federal Employer Identification Number: 04-3419100

Applicant's Legal Name: Walnut Hill Properties Corporation

Applicant's Address (with Zip Code): 47 Winthrop St, Medford MA 02155

Mailing Name (where we should send correspondence to): same

Mailing Address (with Zip Code): \_\_\_\_\_

Emergency Contact: Robert O. Chihade Phone: 781-391-5300

Type of Business (Check Only One and Provide the Names Indicated):

**Sole Proprietor:** Name of Owner: \_\_\_\_\_

**Partnership (inc. LLP):** Name of Partnership: \_\_\_\_\_

Names of All Partners Who Own More Than 10%: \_\_\_\_\_

\_\_\_\_\_

**Trust:** Name of Trust: \_\_\_\_\_

Names of All Trustees Who Own More Than 10%: \_\_\_\_\_

\_\_\_\_\_

**Corporation:** Name of Corporation: Walnut Hill Properties Corp

Name of President: Linda Snyder

Name of Secretary: Robert O. Chihade Name of Treasurer: Thomas S. McGurty

**LLC:** Name of LLC: \_\_\_\_\_

Names of All Managers Who Own More Than 10%: \_\_\_\_\_

\_\_\_\_\_

**Other** (Attach a Description of the Form of Ownership and the Names of Owners)

Business (DBA) Name: Theta Chi

Number of residents at this lodging house: 11

**ACKNOWLEDGEMENT**

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this license. This license will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville. I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all State tax returns and paid all State taxes required under law.

Signature of Applicant: [Signature] Date: 7/1/15

Print Name: Robert O. Chihade Phone: 781-391-5306

Obtain the signatures below before submitting this form to the City Clerk for consideration by the Board of Aldermen.

<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied Date <u>7/13/15</u> <u>[Signature]</u> Police Chief or Designee <u>Deputy Chief</u>	<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied Date <u>7/7/15</u> <u>[Signature]</u> Chief Fire Engineer or Designee
<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied Date <u>7/7/15</u> <u>[Signature]</u> Highways, Lights & Lines Sup't or Designee	<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied Date <u>7/7/15</u> <u>[Signature]</u> Building Inspector or Designee
<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied Date <u>7-7-15</u> <u>[Signature]</u> Health Inspector or Designee	





City of Somerville, Massachusetts  
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Walnut Hill Properties Corporation  
Address of taxpayer/applicant's business: ~~in Somerville:~~ 47 Winthrop St, Medford MA 02155  
Address of taxpayer/applicant's home in Somerville: - 100 Packard Ave  
Taxpayer/applicant's phone: day: 781-391-5300 evening: 781-391-5300

I, (print name) Robert O. Chihade, the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and all taxes and fees due the City have been paid or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY, this 1st day of July, 20 15. [Signature]  
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: 7-7-15 INCLUDES RELEVANT POSTINGS THROUGH: \_\_\_\_\_

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

Real Estate       Water/Sewer       Personal Property       Other: \_\_\_\_\_  
# 11677      # 334089001      # \_\_\_\_\_      # \_\_\_\_\_

NOTES:

CLERK'S INITIALS: JK

ORIGINAL STAMP:





The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.  
 TO BE FILED WITH THE PERMITTING AUTHORITY.

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: Trustees of Tufts College and Walnut Hill Properties Corp.

Address: 169 Holland Street

City/State/Zip: Somerville, MA 02144 Phone #: 617-627-3981

<p><b>Are you an employer? Check the appropriate box:</b></p> <p>1. <input checked="" type="checkbox"/> I am a employer with <u>4,500</u> employees (full and/ or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]</p> <p>3. <input type="checkbox"/> We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p><b>Business Type (required):</b></p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input checked="" type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
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\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.  
 \*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

*I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.*

Insurance Company Name: Self-Insured with Excess insurance through New York Marine & General Ins. Co.

Insurer's Address: 59 Maiden Lane, Suite 2700

City/State/Zip: New York, NY 10038-4647

Policy # or Self-ins. Lic. # SI Lic. # 702; XS Policy # W2015EPP00063 Expiration Date: Both 07/01/2016

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

*I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.*

Signature: [Handwritten Signature] Date: 7/11/2015

Phone #: 617-627-3981

**Official use only. Do not write in this area, to be completed by city or town official.**

City or Town: \_\_\_\_\_ Permit/License # \_\_\_\_\_

Issuing Authority (circle one):  
 1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office  
 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/1/2015
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**THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.**

**IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).**

<b>PRODUCER</b> Risk Strategies Company 160 Federal Street  Boston MA 02110	<b>CONTACT NAME:</b> Leslie Emack <b>PHONE (A/C, No, Ext):</b> (617) 330-5700 <b>FAX (A/C, No):</b> (617) 439-3752 <b>E-MAIL ADDRESS:</b> lemack@risk-strategies.com
<b>INSURER(S) AFFORDING COVERAGE</b>	
INSURER A: New York Marine & General Ins Co	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

**COVERAGES**      **CERTIFICATE NUMBER: CL157196473**      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSP	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY  <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED      RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	WC2015EPP00063	7/1/2015	7/1/2016	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
 Issued as Evidence of Insurance.

<b>CERTIFICATE HOLDER</b>  Tufts University 169 Holland Street Somerville, MA 02144	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE Michael Christian/LEM
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