IMPORTANT

Dear License Holder:

It is time to renew the license issued by the Somerville Board of Aldermen. We are converting to a new software system, and you will see below the information we have on file for your license. Please fill out all six boxes below with the correct information so we can update our records, and return all of the pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

License Type: Extended Operating Hours
License Number: #191175
Business Name: Dunkin Donuts
Location: 282 Somerville Ave
Special Conditions (if any): Su-Sa, 24 Hrs,

Renewal Fee (Return with this application): $550

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business: Dunkin Donuts
Somerville Address and Zip Code: 282 Somerville Ave 02143
Phone Number of the Business: 781 391-7590

The Legal Name of the License Holder: DALEL Corporation
Street Address of the License Holder: 430 Salem St.
City, State and Zip Code of the License Holder: Medford MA 02155
Phone Number of the License Holder: 781 391 7590
Email Address of the License Holder: mwest@dalelcarom

Where We Should Send Mail: Name: DALEL Corp
Street Address: 430 Salem St.
City, State and Zip Code: Medford MA 02155
Email: mwest@dalelco.com
Phone Number: 781 391-7590

Federal ID # (Do Not Give a Social Security #): 04 2624620

Emergency Contact and Phone (For Fire Dept. Use): Ralph D'Agostino 781 953-6305

-OVER-

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

___Sole Proprietor: Name of Owner:_____

___...rtnership (inc. LLP): Names of All Partners Who Own More Than 10%:_____

_____

___Trust: Names of All Trustees Who Own More Than 10%:_____

_____

✓Corporation (inc. LLC): Name of President: Michele Lawlor

Name of Secretary: Ralph D'Alelio

Name of Treasurer: Gary D'Alelio

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

ACKNOWLEDGEMENT: 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 Somerville Board of Aldermen.
-I have filed all State tax returns and paid all State taxes required by law for this business.

License Holder Signature: Michele Lawlor **Date**_____

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: DALEL Corporation

Address of taxpayer/applicant's business in Somerville: 282 Somerville Ave

Address of taxpayer/applicant's home in Somerville: _____

Taxpayer/applicant's phone: day: 781 391-7590 evening: _____

I, (print name) Michele Lawlor, 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 29th day of March, 2012. Michele Lawlor
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____ **INCLUDES RELEVANT POSTINGS THROUGH:** _____

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate	☐ Water/Sewer	☐ Personal Property	☐ Other: ___
# 04218152 MMMMM	# 12005101	# 1105	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** RECEIVED 4-12-12

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Business

Applicant information:

Name: DAEL Corporation

Address: 280 Somerville Ave

City: Somerville State: MA Zip: 02143 Phone #: 781 391-7590

- [x] I am an employer with _____ employees (full and/or part time).
- [ ] I am a sole proprietor or partnership and have no employees.
- [ ] We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees.
- [ ] We are a nonprofit organization staffed by volunteers and have no employees.

Business Type:

- [x] Retail
- [ ] Restaurant/Bar/Eating Establishment
- [ ] Office and/or Sales (real estate, auto, etc.)
- [ ] Nonprofit
- [ ] Entertainment
- [ ] Manufacturing
- [ ] Health Care
- [ ] Other_____

Workers' compensation insurance information (if applicable):

Insurance Company Name: Travelers Insurance

Address: PO Box 1450

City: Middleboro State: MA Zip: 02344 Phone #:

Policy #: YDTANUB-2629T37-9-12 Expiration Date: 1-1-13

Applicant certification:

Failure to secure coverage as required under Section 25A of MGL 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one years' imprisonment as well as civil penalties in the form of a STOP WORK ORDER and a fine of $100.00 a day against me. I understand that a copy of this statement may be forwarded to the Office of Investigations of the DIA for coverage verification.

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

Signature: Michele Lawlor Date: 3/29/2012

Print Name: Michele Lawlor

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

*City or Town:*_____ *Permit/License #:*_____

- [ ] *Board of Health*
- [ ] *Building Department*
- [ ] *City/Town Clerk*
- [ ] *Licensing Board*
- [ ] *Selectmen's Office*
- [ ] *Other*_____

*Contact Person:*_____ *Phone #:*_____

(revised Jan. 2008)

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111

617–727–4900 — http://www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above mentioned chapter by insuring with:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

P.O. BOX 1450
MIDDLEBORO, MA 02344-1450

ADDRESS OF INSURANCE COMPANY

(XDTANUB-3629T37-9-12) 01-01-12 TO 01-01-13

POLICY NUMBER EFFECTIVE DATES

FRED C CHURCH INC 41 WELLMAN ST

LOWELL MA 01851

NAME OF INSURANCE AGENT ADDRESS PHONE #

FELLSWAY DONUTS INC DBA DUNKIN
SEE ENDORSEMENT WC 99 06 01

282 SOMERVILLE AVE

SOMERVILLE
MA 02143

EMPLOYER ADDRESS

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

W20P1G02