



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

Application to Renew Flammables License

BROADWAY PETROLEUM INC
1284 BROADWAY
SOMERVILLE MA 02144

License #: BL15-000506
File #: 15-402
Fee: 550

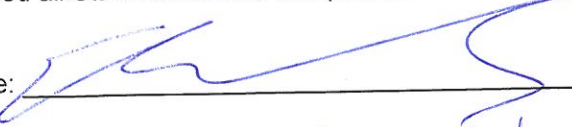
Review and update the information below. If you have workers compensation insurance, attach proof showing the insurer and policy number. Then sign the Acknowledgment and return this form with your fee to the City Clerk's Office.

INFORMATION ON FILE:	CHANGES: (Note below or explain on a separate sheet)
Business/DBA Name: BROADWAY PETROLEUM INC Business Location: 1284 BROADWAY Business Phone: 617-623-9110	
License Holder: BROADWAY PETROLEUM INC 1284 BROADWAY SOMERVILLE MA 02144	
Mailing Address: BROADWAY PETROLEUM INC 1284 BROADWAY SOMERVILLE MA 02144	
Business Type: Corporation ELIAS ELKHAOULI ELIAS ELKHAOULI ELIAS ELKHAOULI	
FID: 043203686	
Emergency Contact: ELIAS ELKHAOULI Phone: 781-233-3069	
# of Gallons of Flammables to be Stored: 23000 Describe Flammables to be Stored: Not yet provided. Proposed Hours of Operation: Not yet provided.	

2015 APR 15 A 11:01
 CITY CLERK'S OFFICE
 SOMERVILLE, MA

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: 4-14-15

Printed Name: Eli Elkhaouli Phone: 617-623-9110



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: dba Truck SQ Auto. Broad way, petaluma;

Address of taxpayer/applicant's business in Somerville: 1284 Broadway

Address of taxpayer/applicant's home in Somerville: 6 Jeffrey St Somers MA

Taxpayer/applicant's phone: day: 617-623-9110 evening: 781-233-3069

I, (print name) Eli Elkhouli, 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 14 day of

4, 2015. [Signature]
(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: _____

2391 # 335029011 # 290 # _____

NOTES:

CLERK'S INITIALS: UB

ORIGINAL STAMP:  UBanaw
4-15-15

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

Workers' Compensation Insurance Affidavit - General Businesses

Applicant information:

Name: BROADWAY RETAIL MERCHANTS INC dba TRUCKS & AUTO
 Address: 1284 BROADWAY
 City: SARASOTT State: MA Zip: 01144 Phone #: 617-673-9110

- | | |
|--|--|
| <input type="checkbox"/> I am an employer with _____ employees (full and/or part time). | <input type="checkbox"/> Retail |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees. | <input type="checkbox"/> Restaurant/Bar/Eating Establishment |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. | <input type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees. | <input type="checkbox"/> Nonprofit |
| | <input type="checkbox"/> Entertainment |
| | <input type="checkbox"/> Manufacturing |
| | <input type="checkbox"/> Health Care |
| | <input type="checkbox"/> Other <u>Gas station</u> |

Workers' compensation insurance information (if applicable):

Insurance Company Name: MA Retail Merchants Inc Group, INC
 Address: P.O. Box Braintree MA 01857
 City: Braintree State: MA Zip: _____ Phone #: 781-848-7652
 Policy #: 014005032200115 Expiration Date: 1-1-16

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: [Signature] Date: 4-4-15
 Print Name: ELI ELKHAOL

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

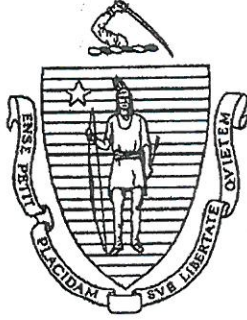
City or Town: _____ Permit/License #: _____

Contact Person: _____ Phone #: _____

<input type="checkbox"/> Board of Health
<input type="checkbox"/> Building Department
<input type="checkbox"/> City/Town Clerk
<input type="checkbox"/> Licensing Board
<input type="checkbox"/> Selectmen's Office
<input type="checkbox"/> Other _____

(revised Jan. 2008)

NOTICE
TO
EMPLOYEES



NOTICE
TO
EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - <http://www.state.ma.us/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:

MA Retail Merchants WC Group Inc.

NAME OF INSURANCE COMPANY	
PO Box 859222-9222 Braintree, MA 02185	
ADDRESS OF INSURANCE COMPANY	
014005032200115	1/01/2015 - 1/01/2016
POLICY NUMBER	EFFECTIVE DATES
Dowling Insurance Agency, Inc.	PO Box 850962 Braintree, MA 02185
NAME OF INSURANCE AGENT	ADDRESS
Teele Square Auto	1284 Broadway Street Somerville, MA 02144
NAME OF INSURANCE AGENT	PHONE #
TEELE SQUARE AUTO	781-848-7652
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	