



CITY OF SOMERVILLE
BOARD OF ALDERMEN
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143
(617) 625-6600

DEC 29 P 12:55
CLERK'S OFFICE
SOMERVILLE, MA

APPLICATION TO RENEW OUTDOOR SEATING LICENSE

MAYA SOL MEXICAN GRILL LLC
MAYA SOL MEXICAN GRILL
179 BROADWAY
SOMERVILLE, MA 02145

License #: 1110

Fee: .00

Account ID: 876

Reference #: 1110

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: MAYA SOL MEXICAN GRILL Business Location: 179 BROADWAY Business Phone: (617)776-9179	
License Holder: MAYA SOL MEXICAN GRILL LLC MAYA SOL MEXICAN GRILL 179 BROADWAY SOMERVILLE, MA 02145 (617)776-9179	
Mailing Address: MAYA SOL MEXICAN GRILL LLC MAYA SOL MEXICAN GRILL 179 BROADWAY SOMERVILLE, MA 02145	
Business Type: CORPORATION (INC. LLC) MANAGER - LUIS MORALES	
FID: 262396100	
Food Manager/Emergency Contact: BENJAMIN ARGUETA 857-259-8240	

Conditions: (to change any conditions, submit a new application. Contact the City Clerk's Office for more information)

Hours: **MO-SU 5-10PM SEATS/9PM GOODS**

12 SEATS
3 TABLES

Description of Location and/or Other Conditions:

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: *Benjamin Argueta*

Date: 10-25-14

Print Name: Benjamin Argueta

Phone: 857 259 8240



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Maya Sol Mexican Grill

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

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

Taxpayer/applicant's phone: day: 957 259 8240 evening: 957 259 8240

I, (print name) Benjamin Argueta, 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 December, 20 14.
B. Argueta
(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: _____

_____ # 101027011 # 142 # _____

NOTES:

CLERK'S INITIALS: SR

ORIGINAL STAMP: 

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: Maya Sol Mexican Grill
Address: 179 Broadway Somerville
City: Somerville State: MA Zip: 02145 Phone #: 617 776 9179

- | | | |
|--|-----------------------|---|
| <input type="checkbox"/> I am an employer with _____ employees (full and/or part time). | Business Type: | <input type="checkbox"/> Retail |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees. | | <input checked="" 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 _____ |

Workers' compensation insurance information (if applicable):

Insurance Company Name: Mutual Insurance Company
Address: P.O. Box 40399
City: New Bedford State: MA Zip: 02744 Phone #: 508 994 9688
Policy #: 400 7026296 2014A Expiration Date: 9-19-2015

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: *Benjamin Argueta* Date: _____

Print Name: Benjamin Argueta

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

City or Town: _____	Permit/License #: _____	<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
Contact Person: _____	Phone #: _____	<input type="checkbox"/> Other _____

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).

PRODUCER 01958 - 001

Flagship Insurance Agency Inc
P O Box 40399
New Bedford, MA 02744

CONTACT

NAME:

PHONE (A/C No. Ext): (508)994-9688

FAX (A/C No.): (508)991-5461

EMAIL

ADDRESS:

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURER A: A.I.M. Mutual Insurance Company

26158

INSURER B:

INSURER C:

INSURER D:

INSURER E:

INSURER F:

INSURED

Maya Sol Mexican Grill LLC

179 Broadway
Somerville, MA 02145

REVISION NUMBER:

COVERAGES

CERTIFICATE 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 SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY					EACH OCCURRENCE \$
	<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY					DAMAGE TO RENTED PREMISES (Ea occurrence) \$
	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR					MED EXP (Any one person) \$
						PERSONAL & ADV INJURY \$
						GENERAL AGGREGATE \$
						PRODUCTS - COMP/OP AGG \$
	GEN'L AGGREGATE LIMIT APPLIES PER:					
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO					BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS	<input type="checkbox"/> SCHEDULED AUTOS				BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS	<input type="checkbox"/> NON-OWNED AUTOS				PROPERTY DAMAGE (Per accident) \$
						\$
	UMBRELLA LIAB	<input type="checkbox"/> OCCUR				EACH OCCURRENCE \$
	EXCESS LIAB	<input type="checkbox"/> CLAIMS MADE				AGGREGATE \$
						\$
	DED	RETENTION \$				
A	WORKERS COMPENSATION AND EMPLOYERS LIABILITY					<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N				E.L. EACH ACCIDENT \$ 100,000.00
	If yes, describe under DESCRIPTION OF OPERATIONS below	Y	AWC-400-7026296-2014A	4/19/2014	4/19/2015	E.L. DISEASE - EA EMPLOYEE \$ 100,000.00
		N/A				E.L. DISEASE - POLICY LIMIT \$ 500,000.00

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

City of Somerville
179 Broadway
Somerville, MA 02143

CANCELLATION

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

Robert Cella

© 1988-2010 ACORD CORPORATION. All rights reserved.

ACORD 25 (2010/05)

The ACORD name and logo are registered marks of ACORD

2246