

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: #191613

Business Name: Golden Light Restaurant

Location: 24 College Ave

Special Conditions (if any): Su-Th to 1:30AM, Fr-Sa to 2AM,

Renewal Fee (Return with this application): \$550

2012 MAY 16 PM 4:22
CITY CLERK'S OFFICE
SOMERVILLE, MA

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business: GOLDEN LIGHT RESTAURANT
Somerville Address and Zip Code: 24 COLLEGE AVE MA 02144
Phone Number of the Business: 617-666-9822

The Legal Name of the License Holder: HO PHUNG LAM
Street Address of the License Holder: 29 PURITAN DR
City, State and Zip Code of the License Holder: QUINCY MA 02169
Phone Number of the License Holder: 617-773-4965
Email Address of the License Holder: _____

Where We Should Send Mail: Name: GOLDEN LIGHT REST.
Street Address: 24 COLLEGE AVE
City, State and Zip Code: SOMERVILLE MA 02144
Email: _____
Phone Number: 617-666-9822

Federal ID # (Do Not Give a Social Security #): 04-2901341

Emergency Contact and Phone (For Fire Dept. Use): MAX LAM - 617-216-4141

-OVER-

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

Sole Proprietor: Name of Owner: _____

Partnership (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: _____

Name of Secretary: _____

Name of Treasurer: _____

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: _____

Date 5-17-12



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: HO CHING LAM

Address of taxpayer/applicant's business in Somerville: 24 COLLEGE AVE. SOMERVILLE

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

Taxpayer/applicant's phone: day: 617-113-965 evening: 617-666-9822

I, (print name) HO CHING LAM, 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 19th day of MAY, 20 12.
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____ INCLUDES RELEVANT POSTINGS THROUGH: _____

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

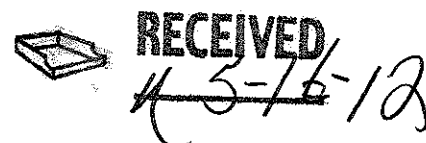
☐ Real Estate ☐ Water/Sewer ☐ Personal Property ☐ Other: _____

19621018 # 311022001 # 08210033 # _____

NOTES: 369 361

CLERK'S INITIALS: a

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: GOLDEN LIGHT RESTAURANT
Address: 24 COLLEGE AVE
City: SOMERVILLE State: MASS Zip: 02144 Phone #: 617-666-9822

- ☐ 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: ☐ 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: PUBLIC SERVICE MUTUAL INSURANCE CO.
Address: ONE PARK AVE.
City: NEW YORK State: N.Y. Zip: 10016 Phone #:
Policy #: NC010948 Expiration Date: 6-1-13

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: [Signature] Date: 5-14-12
Print Name: HONG LAM

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 #: _____

☐ Board of Health
☐ Building Department
☐ City/Town Clerk
☐ Licensing Board
☐ Selectmen's Office
☐ Other _____

Public Service Mutual Insurance Company

One Park Avenue
New York, NY 10016-5807

WORKERS COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE POLICY

INFORMATION PAGE

NCCI Company No: 16152

RENEWAL

Prior Policy Number: WC 010948 11

Policy Number: WC 010948 12

1. Named Insured and Mailing Address:

Lam's Inc d/b/a Golden Light Restaurant
24 College Ave
Somerville, MA 02144-1914

Producer and Mailing Address:

Richard Soo Hoo Insurance Agency, Inc.
1148 Washington Street
Boston, MA 02118
Tel. (617) 338-8168

The Insured: Corporation

Other workplaces not shown above:

Named Insured: Lam's Inc d/b/a Golden Light Restaurant

2. The policy period is from **6/1/2012** to **6/1/2013** 12:01 A.M. Standard Time at your mailing address shown above.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers' Compensation Law of the states listed here: **Massachusetts**

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident	\$ <u>500,000</u>	each accident
Bodily Injury by Disease	\$ <u>500,000</u>	policy limit
Bodily Injury by Disease	\$ <u>500,000</u>	each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

D. This policy includes the following endorsements and schedules:

See Extension of Information Page

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

<u>Classifications</u>	<u>Loc.</u> <u>St.</u>	<u>Code</u> <u>No.</u>	<u>Premium Basis</u>	<u>Rate Per</u>	<u>Estimated</u>
			<u>Total Estimated</u> <u>Annual Remuneration</u>	<u>\$100 of</u> <u>Remuneration</u>	<u>Annual</u> <u>Premium</u>

See Extension of Information Page

\$1,074

Loss Constant: \$0

Expense Constant Charge:

\$250

Minimum Premium \$ 216

Deposit Premium \$ 1,324

Total Estimated Annual Premium:

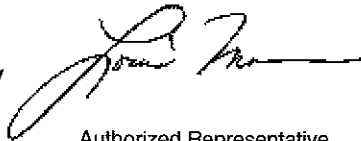
\$1,324

Premium Adjustment Period: Annually

Servicing Office: New England Branch

Countersigned 4/2/2012 at New York, N.Y.

by



Authorized Representative

THIS INFORMATION PAGE WITH THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY AND ENDORSEMENTS, IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETES THE ABOVE NUMBERED POLICY.

Edition 10/97

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