

**APPLICATION FOR OUTDOOR SEATING, GOODS  
OR OTHER PROPERTY ON CITY SIDEWALKS**

Application Fee \$150.00

Date 5-1-12

FOR CITY CLERK'S OFFICE ONLY

Date Recorded \_\_\_\_\_

Amount Paid \_\_\_\_\_

☐ New Application

☐ Renewing Application with Additions or Changes

☒ Renewing Application with NO Additions or Changes

Business (DBA) Name: Kickass Cupcakes Inc. Phone: 617-223-2877

Business Location (with Zip Code): 378 Highland Ave. Somerville, MA 02144

Applicant's Legal Name: Sara Ross

Applicant's Address (with Zip Code): 10 Milton St. #2 Dorchester, MA 02124

Applicant's Email Address: Sara@kickasscupcakes.com

Applicant's Federal Employer Identification Number: 27-1516812

Mailing Name (where we should send correspondence to): Kickass Cupcakes

Mailing Address (with Zip Code): 378 Highland Ave. Somerville, MA 02144

Emergency Contact: Sara Ross Phone: 617-223-7070

Type of Business (Check one): ☐ Sole Proprietor ☐ Partnership (inc. LLP) ☐ Trust

☒ Corporation (inc. LLC) ☐ Other \_\_\_\_\_

**IF A SOLE PROPRIETOR:**

Owner's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

**IF A PARTNERSHIP, TRUST OR CORPORATION (Attach additional sheets as needed):**

Partner's/Member's/President's Name: Sara Ross

Address with Zip Code: 10 Milton St. #2 Dorchester, MA 02124

Partner's/Member's/Secretary's Name: Kevin Ross

Address with Zip Code: 10 Milton St. #2 Dorchester, MA 02124

Partner's/Member's/Treasurer's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

Detailed description of the request, including the proposed quantity and location of items to be placed on the public way. For seating, attach a plan on 8½" x 11" paper, showing the location and dimensions of the seating, the sidewalk, and any signs, trees, or other obstructions. \_\_\_\_\_

2 tables 8 chairs

#### RELEASE AND INDEMNITY AGREEMENT TO ENCUMBER A PUBLIC WAY

I, the undersigned Applicant or Duly Authorized Agent, hereby agree to release, discharge and hold harmless, the City of Somerville, a municipal corporation of the Commonwealth of Massachusetts, and its officers, employees, agents and servants from all actions, causes of action, claims, demands, damages, costs, loss of services, expenses and compensation associated with the undersigned's use of the public way as described herein.

Signature of Applicant: \_\_\_\_\_ Date: 5-1-12

#### FOR ALL NEW OR CHANGING APPLICATIONS:

##### CITY ENGINEER APPROVAL:

Approval granted not to exceed \_\_\_\_\_ tables.

Approval granted not to exceed \_\_\_\_\_ chairs.

Approval granted not to exceed \_\_\_\_\_ sign(s) or other: \_\_\_\_\_

Additional conditions \_\_\_\_\_

Signature: \_\_\_\_\_ Name and Title: \_\_\_\_\_

#### FOR NEW COMMON VICTUALLER APPLICATIONS FOR OUTDOOR SEATING:

##### INSPECTIONAL SERVICES DEPARTMENT APPROVAL:

Approval granted not to exceed \_\_\_\_\_ tables.

Approval granted not to exceed \_\_\_\_\_ chairs.

Approval granted not to exceed \_\_\_\_\_ sign(s) or other: \_\_\_\_\_

Additional conditions \_\_\_\_\_

Signature: \_\_\_\_\_ Name and Title: \_\_\_\_\_

## 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.

Signature of Applicant: \_\_\_\_\_

Date: 5-1-12

Print Name: \_\_\_\_\_

Sara Bess

Phone: 617-628-2877

## OTHER CONDITIONS

1. This permit is issued annually and is valid through December 31.
2. The Applicant agrees to use only those items as described in the description or attached plan, and maintain a minimum clearance of 42" on the sidewalk at all times.
3. The Applicant agrees to submit a City and County Licenses and Permits Bond in the amount of \$5,000, or a current Certificate of Insurance listing the City of Somerville as an Additional Insured on the business liability insurance in a form satisfactory to the City before the Permit will be issued.
4. For outdoor seating,
  - a. The Applicant agrees to install a containment system, which is satisfactory to the City, around the periphery of the outdoor seating area in order to delineate and separate the proposed use from the public sidewalk.
  - b. The Applicant agrees to close all outdoor seating no later than 10:00 PM.
  - c. The Applicant acknowledges that the service of alcohol in the outdoor seating area is prohibited, and may result in criminal and/or civil sanctions, unless separately licensed by the Licensing Commission.
  - d. The Applicant agrees to the placement and regular maintenance of a trash receptacle on the sidewalk in front of the business in order to minimize extra litter associated with outdoor seating.
5. For goods and property placed on the way exclusive of outdoor seating,
  - a. The Applicant agrees to remove all goods and other property from the public way no later than 9:00 PM.

6. \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: 5-1-12



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
5/2/2012

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 15 Pacella Park Drive Suite 240 Randolph MA 02368		<b>CONTACT NAME:</b> Gayle McLean <b>PHONE (A/C, No, Ext):</b> (617) 330-5700 <b>FAX (A/C, No):</b> (781) 963-4420 <b>E-MAIL ADDRESS:</b> <b>PRODUCER CUSTOMER ID #:</b>	
<b>INSURED</b> Kickass Cupcakes 378 Highland Ave Somerville MA 02144		<b>INSURER(S) AFFORDING COVERAGE</b> INSURER A: Lexington Insurance Co INSURER B: Travelers Insurance Co INSURER C: INSURER D: INSURER E: INSURER F:	

**COVERAGES** **CERTIFICATE NUMBER:** CL1233046267 **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.

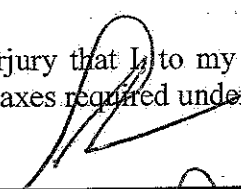
INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		6804A054105	7/14/2011	7/14/2012	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/POP AGG \$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS					
	BA7436X431 6/16/2011 6/16/2012 COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$					
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB DEDUCTIBLE RETENTION \$	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE	CUP006B6123	3/26/2012	7/14/2012	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000 \$ \$
A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input type="checkbox"/> N/A				WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
	Property					
	6804A054105 7/14/2011 7/14/2012					
	Business Personal Property \$120,000					

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES** (Attach ACORD 101, Additional Remarks Schedule, if more space is required)  
Issued as Evidence of Insurance. City of Somerville is included as additional insured as respect to General Liability per policy provisions.

<b>CERTIFICATE HOLDER</b> City of Somerville	<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/KDG <i>M B Christian</i>
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**MASSACHUSETTS DEPARTMENT OF REVENUE  
REVENUE ENFORCEMENT AND PROTECTION (REAP)  
ATTESTATION**

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 Individual or Corporate Name (Mandatory)

*Kickass Cupcakes Inc*

  
\_\_\_\_\_  
By: Corporate Officer (Mandatory, if a corporation)

*Sara Ross*

*27-1516812*

\_\_\_\_\_  
\*\*Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

\* This license will not be issued unless this certification clause is signed by the applicant.

\*\* Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.



City of Somerville, Massachusetts  
Finance Department, Treasury Division

**WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.**

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: Kickass Cupcakes Inc.

Address of taxpayer/applicant's business in Somerville: 378 Highland Ave. Somerville, MA 02144

Address of taxpayer/applicant's home in Somerville: N/A

Taxpayer/applicant's phone: day: 617-628-2877 evening: 617-223-7070

I, (print name) Sara Ross, 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

May, 20 12.  
(Taxpayer's signature)

**CITY'S ACKNOWLEDGEMENT**

DATE OF ISSUANCE: \_\_\_\_\_ INCLUDES RELEVANT POSTINGS THROUGH: \_\_\_\_\_

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

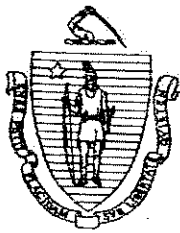
<input type="checkbox"/> Real Estate	<input type="checkbox"/> Water/Sewer	<input type="checkbox"/> Personal Property	<input type="checkbox"/> Other: _____
# <u>7213</u>	# <u>31607700</u>	# <u>640</u>	# _____

NOTES:

CLERK'S INITIALS: \_\_\_\_\_

ORIGINAL STAMP: \_\_\_\_\_

RECEIVED  
4-5-10-12



The Commonwealth of Massachusetts  
Department of Industrial Accidents  
Office of Investigations  
600 Washington Street  
Boston, MA 02111  
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

**Applicant Information**

Please Print Legibly

Business/Organization Name: Kickass Cupcakes Inc

Address: 378 Highland Ave.

City/State/Zip: Somerville, MA

Phone #: 617-628-2877

**Are you an employer? Check the appropriate box:**

1. ☒ I am a employer with 15 employees (full and/or part-time).\*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ 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]\*\*
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

**Business Type (required):**

5. ☒ Retail
6. ☒ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other \_\_\_\_\_

\*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: MA Retail Merchants WC Group Inc.

Insurer's Address: P.O. Box 859 222-9222

City/State/Zip: Braintree, MA 01285

Policy # or Self-ins. Lic. #: 014005032401112

Expiration Date: 1-1-13

**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: \_\_\_\_\_

Date: 5-1-12

Phone #: \_\_\_\_\_

617-628-2877

**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 #: \_\_\_\_\_

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE CERTIFICATE

INFORMATION PAGE

RENEWAL AGREEMENT

MA Retail Merchants WC Group Inc.  
PO Box 859222-9222  
Braintree, MA 01285  
(Carrier Code: 34355)

Producer: Agent# 960  
Association Benefits Ins Agcy Inc  
210 Broadway, Unit 201  
Lynnfield, MA 01940  
Certificate #: 014005032401112  
Prior Certificate #: 014005032401111

1. The Employer: Kickass Cupcakes, Inc.  
Mailing Address: 378 Highland Ave  
Somerville, MA 02144

Other workplaces not shown above:  
SEE SCHEDULE OF OPERATIONS

Fein: 001017827  
Type of Business: Limited Liability Co  
Risk ID:

2. The certificate period is from 12:01 a.m. on 1/01/2012 to 12:01 a.m. on  
1/01/2013 at the insured's mailing address.

3. A. Workers Compensation Coverage: Part One of the certificate applies to the  
Workers Compensation Law of the states listed here:  
MA

- B. Employers Liability Coverage: Part Two of the certificate 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>100,000</u>	each accident
Bodily Injury by Disease	\$ <u>500,000</u>	certificate limit
Bodily Injury by Disease	\$ <u>100,000</u>	each employee

- C. Other States Coverage:

- D. This certificate includes these endorsements and schedules:

WC000000A(04/92) WC000310(04/84) WC000414(07/90) WC000422A(09/08) WC200301(04/84)  
WC200302(05/86) WC200303B(07/99) WC200405(06/01) WC200601(06/92)

4. The contribution for this certificate 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.

Classifications	Code No.	Contribution Basis Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Contribution
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SEE SCHEDULE OF OPERATIONS

Total Estimated Annual Contribution 5,888.00

Minimum Contribution \$ 276.00 Expense Constant \$ .00

WC 00 00 01 A Issue Date: 1/25/2012

Countersigned by \_\_\_\_\_