10 autos in

SECOND HAND MOTOR VEHICLE DEALER LICENSE APPLICATION

Application Fee $500.00

Date 12/30/2010

FOR CITY CLERK'S OFFICE ONLY
Date Recorded 12-30-2010
Amount Paid 500- CK 2704

__ New Application Check one: __ Class 1 X Class 2 __ Class 3

__ Renewing Application with Additions or Changes

X Renewing Application with NO Additions or Changes

Business Name: Automotive Transport Service 495 Columbia St Somerville Massachusetts 02143 Phone: 623-9522

Business DBA Name (if applicable): _____

Address with Zip Code: _____

Tax Identification Number: 261201652 Check one: __SSN X FEIN

Mailing Name (where we should send correspondence to): 495 Columbia St

Address with Zip Code: 02143

Property Owner Name: Robert Souza Phone: 623 9522

Address with Zip Code: 02143

Emergency Contact 1: Robert Souza Phone: 617 623 9522

Emergency Contact 2: Jennifer Souza Phone: 617-7855224

Type of Business (Check one): __Sole Proprietor __Partnership (inc. LLP) __Trust

X 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: _____

Address with Zip Code: _____

Partner's/Member's/Secretary's Name: _____

Address with Zip Code: _____

Partner's/Member's/Treasurer's Name: _____

Address with Zip Code: _____

CITY CLERK'S OFFICE SOMERVILLE, MA
2010 DEC 30 A 11:09

Are you engaged principally in the business of buying, selling or exchanging motor vehicles? Y X N __

Is your principal business the sale of new motor vehicles? Y __ N X

If yes, are you a recognized agent of a motor vehicle manufacturer, or do you have authority to sell the vehicles of a motor vehicle manufacturer via a written contract? Y __ N X

If yes, provide the name of the manufacturer(s): _____

Is your principal business the buying and selling of second hand motor vehicles? Y X N __

If yes, have you obtained a $25,000 bond pursuant to MGL c. 140 § 58, for this business, at this location? Y X N __

If yes, do you have access to a repair facility to comply with the warranty obligations imposed by MGL c. 90 § 7N¼? Y X N __

If yes, provide the name of the repair facility: 495 Columbia St

Is your principal business that of a motor vehicle junk dealer? Y __ N X

Have you ever obtained a license to deal in second hand motor vehicles or parts? Y X N __

If yes, list year, city and state _____

_____

Have you ever been denied a license to deal in second hand motor vehicles or parts? Y __ N X

If yes, list year, city and state _____

_____

Have you ever had a license to deal in second hand motor vehicles or parts revoked or suspended? Y __ N X

If yes, list year, city and state _____

_____

Describe all of the premises to be used in the business: 14000 Sq Ft Warehouse

_____

The hours of operation for used car dealers are Monday through Friday, 8 AM to 6 PM, Saturday, 8 AM to 2 PM, and Sunday, Closed. If you require different hours of operation, list them and explain:

_____

_____

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 only be effective for the listed location, will expire on December 31, and 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 12/30/10

Business Name: Automotive Transport Service

Business Address: 495 Columbia St Somerville Massachusetts 02143

FOR NEW APPLICANTS:

INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:

The building located at the premises mentioned above is in a _____ Zone.

_____ The use is permitted as of right

_____ The use requires a special permit

_____ The use is prohibited

Class 1 & 2: Maximum number of vehicles to be kept on the premises: _____ inside

_____ outside

Signature:_____ Date:_____

Print Name:_____ Title:_____

POLICE DEPARTMENT RECOMMENDATION:

The Chief of Police recommends that the application be

_____ Approved

_____ Denied

Signature:_____ Name and Title:_____

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: Robert Soura

Address of taxpayer/applicant's business in Somerville: 495 Columbia St

Address of taxpayer/applicant's home in Somerville: 2 Eliot St

Taxpayer/applicant's phone: day: 617-623-9522 evening: 617 625 8697

I, (print name) Robt Soura, 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 30 day of Dec, 2010. _____
(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: ___
# 4002053	# 12407201	#	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** received 12-30-10

SOMERVILLE CITY HALL • 93 HIGHLAND AVENUE • SOMERVILLE MASSACHUSETTS 02143
(617) 625-6600 EXT. 3500 • TTY: (866) 808-4851 • FAX: (617) 666-9682
WWW.SOMERVILLEMA.GOV

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.

Automotive Transport Service Inc

*Signature of Individual or Corporate Name (Mandatory)

X

By: Corporate Officer (Mandatory, if a corporation)

26 1201 6552

**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.

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: Automotive Transport Service

Address: 495 Columbia St Somerville Massachusetts 02143

City: _____ State: _____ Zip: _____ Phone #: 617-623-9522

☐ I am an employer with 7 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: Liberty Mutual

Address: P.O. Box 9102

City: Weston State: MA Zip: 02493 Phone #: 1800 762-3126

Policy #: WC2 315 369660-028 Expiration Date: 10/08/2011

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: _____ Date: 12/30/10

Print Name: _____

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

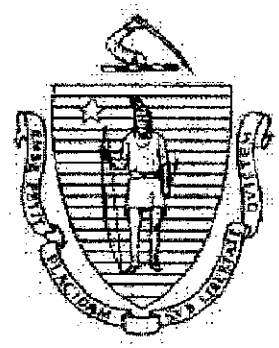
City or Town: _____ ***Permit/License #:*** _____

☐ *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:

LIBERTY MUTUAL FIRE INSURANCE CO
NAME OF INSURANCE COMPANY

PO Box 9102 Weston, MA 02493-9102 1-800-762-5026
ADDRESS OF INSURANCE COMPANY

WC2-31S-369660-020 — 10-09-2010 10-09-2011
POLICY NUMBER — EFFECTIVE DATES

RIDER RISK SPECIALISTS INSURANCE AGENCY — (508)564-7200
NAME OF INSURANCE AGENT — PHONE #

50 ROUTE 28A CATAUMET MA 02534-0115
ADDRESS OF INSURANCE AGENT

AUTOMOTIVE TRANSPORT SERVICE — 495 COLUMBIA STREET
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

Insured Copy