APPLICATION FOR EXTENDED OPERATING HOURS

Application Fee $500.00

Date 3/15/10

FOR CITY CLERK'S OFFICE ONLY
Date Recorded 3-29-2010
Amount Paid 500-00

__ New Application

✓ Renewing Application with Additions or Changes

__ Renewing Application with NO Additions or Changes

CITY CLERK'S OFFICE
2010 MAR 29 A 9:15

Business Name: Hess Corp Phone: 628-3871

Business DBA Name (if applicable): Hess 21521

Address with Zip Code: 709 McGrath Hwy 02145

Tax Identification Number: 13-4921002 Check one: __SSN ✓FEIN

Mailing Name (where we should send correspondence to):

Address with Zip Code:

HESS CORPORATION
1 Hess Plaza / J. Flaherty
Woodbridge, NJ 07095
732-750-6350

Property Owner Name: Phone:

Address with Zip Code:

Emergency Contact 1: William Maldonado - MGR Phone: 617-628-6299

Emergency Contact 2: Bill Maronn-MKTRep Phone: 843-725-9697

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: R. J. Lawlor, VP – 1637 Thistlewood Dr

Address with Zip Code: Washington Crossing, PA 18977

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

Address with Zip Code:

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

Address with Zip Code:

Extended hours requested (include hours of operation and days of week) 24/7

Type of business Gas Station / Convenience Store

Length of time at this location 9 yrs.

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: [signature] Date: 3/15/10

Print Name: JANICE FLAHERTY Phone:

LICENSE COORDINATOR 732 750 6350

POLICE DEPT. (for new applicants or applicants further extending their hours):

The Chief of Police recommends that the application be

_____ Approved

_____ Denied

Signature:_____ Name and Title:_____

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.

Hess Corp

*Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

13-4921002

**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: Hess Corp

Address of taxpayer/applicant's business in Somerville: 709 McGrath Hwy

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

Taxpayer/applicant's phone: day: 732-750-6350 evening: _____

I, (print name) RJ Lawlor VP, 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 15 day of March, 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: ___

13455155 # 14400500 # 30052442

NOTES:

CLERK'S INITIALS: a **ORIGINAL STAMP:** received 4-5-10

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: Hess 21521

Address: 709 McGrath Hwy

City/State/Zip: Somerville MA 02145 Phone #: 617-628-3871

Are you an employer? Check the appropriate box:

1. [X] I am a employer with 5-10 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. [X] 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: Liberty Mutual

Insurer's Address: PO Box 3634

City/State/Zip: Bala Cynwyd PA 19004

Policy # or Self-ins. Lic. # WA7-62D-004329-029 Expiration Date: 9/1/10

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: 3/16/10

Phone #: 732-750-6350

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 #: _____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 08/31/2009

PRODUCER	877-945-7378	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
Willis of New York, Inc. 26 Century Blvd. P. O. Box 305191 Nashville, TN 37230-5191		INSURERS AFFORDING COVERAGE	NAIC#
INSURED	Hess Corporation One Hess Plaza Woodbridge, NJ 07095	INSURER A: Liberty Mutual Insurance Company Inc.	23043-902
		INSURER B: Liberty Mutual Fire Insurance Company	23035-001
		INSURER C: Liberty Insurance Corporation	42404-001
		INSURER D:	
		INSURER E:	

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
A		GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR [X] *SIR - $500,000 GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC	EB1-621-004329-069	9/1/2009	9/1/2010	EACH OCCURRENCE	$ 4,500,000
						DAMAGE TO RENTED PREMISES (Ea occurence)	$
						MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$ 4,500,000
						GENERAL AGGREGATE	$ 5,000,000
						PRODUCTS - COMP/OP AGG	$ 4,500,000
B		AUTOMOBILE LIABILITY [X] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS [X] See Below	AS2-621-004329-019	9/1/2009	9/1/2010	COMBINED SINGLE LIMIT (Ea accident)	$ 5,000,000
						BODILY INJURY (Per person)	$
						BODILY INJURY (Per accident)	$
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT	$
						OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS / UMBRELLA LIABILITY [ ] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] RETENTION $				EACH OCCURRENCE	$
						AGGREGATE	$
							$
							$
							$
C		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH) If yes, describe under SPECIAL PROVISIONS below	WA7-62D-004329-029	9/1/2009	9/1/2010	[X] WC STATU-TORY LIMITS [ ] OTH-ER	
						E.L. EACH ACCIDENT	$ 5,000,000
						E.L. DISEASE - EA EMPLOYEE	$ 5,000,000
						E.L. DISEASE - POLICY LIMIT	$ 5,000,000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

ALL OPERATIONS OF THE INSURED AND ALL OWNED, HIRED AND NON-OWNED VEHICLES.
* ABOVE LIMITS OF LIABILITY APPLY EXCESS OF A $500,000 SELF INSURED RETENTION.

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Coll:2794494 Tpl:969387 Cert:12950381