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

APPLICATION TO RENEW FLAMMABLES LICENSE

LUB-O-LINE INDUSTRIAL OIL CO., INC.
9 FLORENCE ST
SOMERVILLE, MA 02145

License #: **529**
City #F166
Fee: **550.00**
Account ID: **429**
Reference #: **529**

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: **LUB-O-LINE INDUSTRIAL OIL CO., INC.** Business Location: **9 FLORENCE ST** Business Phone: **617-776-4490**	
License Holder: **LUB-O-LINE INDUSTRIAL OIL CO., INC.** **9 FLORENCE ST** **SOMERVILLE, MA 02145** **617-776-4490**	
Mailing Address: **LUB-O-LINE INDUSTRIAL OIL CO., INC.** **9 FLORENCE ST** **SOMERVILLE, MA 02145**	
Business Type: **CORPORATION (INC. LLC)** **PRESIDENT - NORMA WATERMAN** **TREASURER - NORMA WATERMAN** **SECRETARY - RAYMOND HUMES JR.**	
FID: **042227408**	
Food Manager/Emergency Contact: **NORMA WATERMAN** **603-673-6061**	

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

Hours: **MO-SU 5 AM - MIDNIGHT**

Description of Location and/or Other Conditions:

Originally Issued 2/22/1993, 9,000 Gals. Aboveground Fuel Oil In 3 Trucks. Hours Of Operation Monday-Friday 6AM-7PM, Saturday 8AM-1PM, Sunday Closed.

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: Norma Waterman Date _____

Print Name: Norma Waterman Phone 617-776-4490

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Lub-O-Line Industrial Oil Co., Inc.

Address of taxpayer/applicant's business in Somerville: 9 Florence Street

Address of taxpayer/applicant's home in Somerville: 58 Walnut Hill Road Amherst NH 03031

Taxpayer/applicant's phone: day: 617 776 4490 evening: 603 672 9784

I, (print name) Norma Waterman, 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 _____ day of

_____, 20 14. Norma Waterman
(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: ___
# 105-B-00018-0005667	#/08070011	# 122550497	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** RECEIVED 3/5/14

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: Lub-O-Line Industrial Oil Co, Inc.

Address: 9 Florence Street

City: Somerville State: MA Zip: 02145 Phone #: 617 776 4490

[X] I am an employer with 3 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
[XX] Other Resale Oil Fuel

Workers' compensation insurance information (if applicable):

Insurance Company Name: ACE Group

Address: P.O Box 1450

City: Middeboro State: MA Zip: 02344 Phone #: 617 727 4500

Policy #: 6562UB-4682P29-0-13 Expiration Date: 6-2-14

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: Norma Waterman Date: 3-5-14

Print Name: Norma Waterman

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

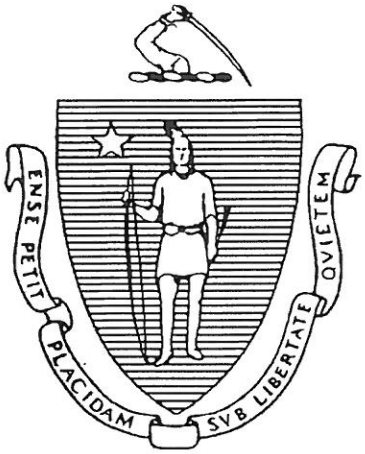
City or Town: _____ *Permit/License #:* _____

Contact Person: _____ *Phone #:* _____

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

(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:

ACE GROUP
NAME OF INSURANCE COMPANY

P.O. BOX 1450
MIDDLEBORO, MA 02344-1450
ADDRESS OF INSURANCE COMPANY

(6S62UB-4682P29-0-13) 06-02-13 TO 06-02-14
POLICY NUMBER EFFECTIVE DATES

BROWN AND BROWN OF NEW — PO BOX 1510 — MERRIMACK — NH 030544116
NAME OF INSURANCE AGENT — ADDRESS — PHONE #

LUB-O-LINE INDUSTRIAL OIL CO INC — 9 FLORENCE STREET — SOMERVILLE MA 02145-4306
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