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

APPLICATION TO RENEW EXTENDED OPERATING HOURS LICENSE

License #: **854**

HESS #21521
ATTN: J. FLAHERTY
1 HESS PLAZA
WOODBRIDGE, NJ 07095

Fee: **550.00**
Account ID: **411**
Reference #: **854**

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: **HESS #21521** Business Location: **709 MCGRATH HWY** Business Phone: **617-628-3871**	
License Holder: **HESS #21521** **709 MCGRATH HWY** **SOMERVILLE, MA 02145** **617-628-3871**	2014 MAR 13 P 12:57 CITY CLERK'S OFFICE SOMERVILLE, MA
Mailing Address: **HESS #21521** **ATTN: J. FLAHERTY** **1 HESS PLAZA** **WOODBRIDGE, NJ 07095**	
Business Type: **CORPORATION (INC. LLC)** **SECRETARY - G C BARRY** **TREASURER - L HORNSTEIN** **PRESIDENT - R J LAWLER**	
FID: **134921002**	
Food Manager/Emergency Contact: **WILLIAM MALDONADO** **617-628-6299**	Ed Salazar 617-792-9992

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

Hours: **SUN-SAT 24 HOURS**

Description of Location and/or Other Conditions:

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: JANICE FLAHERTY Date 3/4/14

Print Name: LICENSE COORDINATOR Phone 732 750 6350

City of Somerville, Massachusetts
Finance Department, Treasury Division

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) David A Klawson's 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 4th day of March, 2014. _____ (Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: 3/3/14 **INCLUDES RELEVANT POSTINGS THROUGH:** 3/2/14

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☑ Real Estate # 9812 ☑ Water/Sewer # 144005 001 ☑ Personal Property # 805 ☑ Other: BL # 1129

NOTES:

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

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
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. ☒ 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. ☒ 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-004329-023 Expiration Date: 9/1/14

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: 3/4/14

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) 08/23/2013

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).

PRODUCER

Willis of New York, Inc.
c/o 26 Century Blvd.
P. O. Box 305191
Nashville, TN 37230-5191

CONTACT NAME:
PHONE (A/C, NO, EXT): 877-945-7378 FAX (A/C, NO): 888-467-2378
E-MAIL ADDRESS: certificates@willis.com

INSURER(S)AFFORDING COVERAGE	NAIC #
INSURER A: Liberty Mutual Fire Insurance Company	23035-001
INSURER B: Liberty Insurance Corporation	42404-001
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

Hess Corporation
One Hess Plaza
Woodbridge, NJ 07095

COVERAGES **CERTIFICATE NUMBER:** 20252467 **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	INSR		POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			EB2621004329063	9/1/2013	9/1/2014	EACH OCCURRENCE	$ 4,500,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurence)	$
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$
	X SIR - $500,000						PERSONAL & ADV INJURY	$ 4,500,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 5,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 4,500,000
								$
A	AUTOMOBILE LIABILITY			AS2621004329013	9/1/2013	9/1/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 5,000,000
	X ANY AUTO						BODILY INJURY(Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY(Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
	X See Below							$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			WA762D004329023	9/1/2013	9/1/2014	X WC STATU-TORY LIMITS OTH-ER	
B	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A		WC7621004329263	9/1/2013	9/1/2014	E.L. EACH ACCIDENT	$ 5,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 5,000,000
							E.L. DISEASE - POLICY LIMIT	$ 5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach Acord 101, Additonal Remarks Schedule, if more space is required)

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.

ADD'L SUBR

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

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

Coll:4192717 Tpl:1691135 Cert:20252467