



CITY OF SOMERVILLE
Commonwealth of Massachusetts
93 Highland Avenue
Somerville, MA 02143
(617) 625-6600

2015 NOV 20 A 10:00

Application to Renew Used Car Dealer License

CITY CLERK'S OFFICE
SOMERVILLE, MA

BROADWAY PETROLEUM INC
1284 BROADWAY
SOMERVILLE MA 02144

License #: BL15-000858
File #: 15-402
Fee: 550

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: TEELE SQUARE AUTO Business Location: 1284 BROADWAY Business Phone: 617-623-9110	
License Holder: BROADWAY PETROLEUM INC 1284 BROADWAY SOMERVILLE MA 02144	
Mailing Address: BROADWAY PETROLEUM INC 1284 BROADWAY SOMERVILLE MA 02144	
Business Type: Corporation ELIAS ELKHAOULI ELIAS ELKHAOULI ELIAS ELKHAOULI	
FID: 043203686	
Emergency Contact: ELIAS ELKHAOULI Phone: 781-233-3069	
Dealership Class: Class 2 # of Vehicles Kept Inside: 0 # of Vehicles Kept Outside: 2 Proposed Hours of Operation if operating outside standard hours: mo -fr 8 am - 6pm, sa 8am - 2pm	

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: _____

Date: _____

Printed Name: _____

Phone: _____

ISSUED THROUGH

A. A. DORITY COMPANY

BOSTON

CONTINUATION CERTIFICATE

The **NGM Insurance Company**, hereinafter called the Company, hereby continues in force its **MA Used Car Dealer** Bond Number **261436**

in the sum of **Twenty-Five Thousand dollars (\$25,000.00)**

on behalf of

Broadway Petroleum, Inc. dba Teele Square Auto

located at

1284 Broadway
Somerville, MA 02144

in favor of **City of Somerville, MA**

for the term beginning **December 31st, 2015** and ending on **December 31st, 2016**, subject to all covenants and conditions of said bond.

This Continuation is executed upon the express condition that the Company's liability shall not be cumulative and shall be limited at all times by the amount of the penalty stated in the bond.

In witness whereof, the Company has caused this instrument to be signed by its duly authorized Attorney-in-Fact and its Corporate Seal to be hereto affixed this day, October 29, 2015

NGM Insurance Company

By: 

Katie E. Ford

Attorney-in-Fact

A. A. DORITY Company, Inc.

262 Washington Street, Suite 99

Boston, MA 02108

(617) 523-2935 Fax: 617-523-1707



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Broadway Petroleum Inc dba Teale SQ Auto

Address of taxpayer/applicant's business in Somerville: 1284 Broad way

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

Taxpayer/applicant's phone: day: 617-623-9110 evening: 617-320-4227

I, (print name) Eli Elkhaoui, 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 19 day of 11, 2015.
(Taxpayer's signature) [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: _____

2400 # 335079011 # 314 # _____

NOTES:

CLERK'S INITIALS: UB

ORIGINAL STAMP:

RECEIVED
UB
11-20-15



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: BROADWAY PETROLEUM INC d/b/a TRIO SA AUTO
Address: 1284 BROADWAY
City/State/Zip: SOMERVILLE MA 02144 Phone #: 617-623-9110

Are you an employer? Check the appropriate box:

1. ☐ I am an employer with _____ 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 Gas station repair

*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 WCGROUP INC
Insurer's Address: Braintree MA PO Box 85962 Douling ins agent Braintree 85962
City/State/Zip: _____

Policy # or Self-ins. Lic. # 014005032200115 Expiration Date: 1-1-16

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: 11-19-15

Phone #: _____

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 #: _____

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - <http://www.state.ma.us/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:

MA Retail Merchants WC Group Inc.

NAME OF INSURANCE COMPANY		
PO Box 859222-9222 Braintree, MA 02185		
ADDRESS OF INSURANCE COMPANY		
014005032200115		1/01/2015 - 1/01/2016
POLICY NUMBER		EFFECTIVE DATES
Dowling Insurance Agency, Inc.	PO Box 850962 Braintree, MA 02185	781-848-7652
NAME OF INSURANCE AGENT	ADDRESS	PHONE #
Teele Square Auto	1284 Broadway Street Somerville, MA 02144	
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	