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

APPLICATION TO RENEW OUTDOOR SEATING LICENSE

License #: **1015**

ABP CORPORATION
AU BON PAIN
1 AU BON PAIN WAY
BOSTON, MA 02210

Fee: **.00**
Account ID: **536**
Reference #: **1015**

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: **AU BON PAIN** Business Location: **40 HOLLAND ST** Business Phone: **617-623-9601**	
License Holder: **ABP CORPORATION** **AU BON PAIN** **1 AU BON PAIN WAY** **BOSTON, MA 02210** **617-623-9601**	
Mailing Address: **ABP CORPORATION** **AU BON PAIN** **1 AU BON PAIN WAY** **BOSTON, MA 02210**	
Business Type: **CORPORATION (INC. LLC)** **TREASURER - MICHAEL LYNCH** **PRESIDENT - SUSAN MORELLI** **SECRETARY - TOM DOLAN**	
FID: **043466910**	
Food Manager/Emergency Contact: **MARIO WATKINS**	

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

Hours: **MO-SU 5-10PM SEATS/9PM GOODS**

68 SEATS
34 TABLES

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: Mario Watkins Date 11-3-2014

Print Name: MARIO WATKINS Phone 617-897-5079

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/29/2014

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
Marsh USA, Inc.
Six PPG Place, Suite 400
Pittsburgh, PA 15222
Attn: Pittsburgh.CertRequest@Marsh.com

101820--ALL-14-15 523

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : LM Insurance Corporation	33600
INSURER B : N/A	N/A
INSURER C : Liberty Mutual Fire Insurance Company	23035
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
ABP CORPORATION
One Au Bon Pain Way
Boston, MA 02210

COVERAGES **CERTIFICATE NUMBER:** CLE-003422288-35 **REVISION NUMBER:** 14

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	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY**			TB5-Z91-438380-034	08/01/2014	08/01/2015	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$ 10,000
	X DEDUCTIBLE: $25,000						PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	X POLICY [ ] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] **UMBRELLA LIAB** [ ] OCCUR						EACH OCCURRENCE	$
	[ ] **EXCESS LIAB** [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N	N / A		WA2-Z9D-438380-014	08/01/2014	08/01/2015	X WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] **(Mandatory in NH)**						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
#523: Davis Square Medical Center 18-48 Holland Street, Somerville, MA 02144

CERTIFICATE HOLDER

Kadima Medical Properties, LLC
c/o KND Management Co. Inc
Attn: Rose Pawlukiewicz
101 Richardson Street
Brooklyn, NY 11211

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
of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee

AGENCY CUSTOMER ID: 101820
LOC #: Pittsburgh

ACORD®

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA, Inc.	ABP CORPORATION One Au Bon Pain Way Boston, MA 02210
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

City of Somerville, MA, KND Management Co. Inc, Managing Agent, Arbor Realty Funding, LLC, 333 Earle Ovington Blvd, Suite 900, Uniondale, New York 11553, and Wells Fargo Bank, NA as successor to Wachovia Bank, NA as Master Service on behalf of Bank of America, NA, as Trustee for the benefit of the Certificate Holders of, Commercial Mortgage pass-through Certificates WB CMT 07-C30, its Successors and/or Assigns, PO Box 563956, Charlotte, NC 28256-3956 are named Additional Insured, excluding Workers Compensation and Employers Liability, as required by written contract but limited to the operations of the Named Insured under said contract and subject to policy terms, conditions and exclusions.

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Au Bon Pain

Address of taxpayer/applicant's business in Somerville: 40 Holland St, Somerville, MA. 02144

Address of taxpayer/applicant's home in Somerville: N/A

Taxpayer/applicant's phone: day: 617-623-9601 evening: _____

I, (print name) MARIO WATKINS of Au Bon Pain, 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____. _____
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: 11/3/14 **INCLUDES RELEVANT POSTINGS THROUGH:** 11/3/14

T/ ..S AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate ☑ Water/Sewer ☑ Personal Property ☐ Other: ___

7695 #661074011 # 619

NOTES:

CLERK'S INITIALS: RJ **ORIGINAL STAMP:**

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

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: AU BON PAIN

Address: ONE AU BON PAIN WAY

City: BOSTON State: MA Zip: 02210 Phone #: 617-897-5079

☐ I am an employer with _____ 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: SEE ATTACHED

Address:

City: State: Zip: Phone #:

Policy #: Expiration Date:

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: 11-3-2014

Print Name: MARIO WATKINS

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)