



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

Application to Renew Used Car Dealer License

HERB CHAMBERS I-93 INC
257 MCGRATH HWY
SOMERVILLE MA 02143

License #: BL15-000003
File #: 15-5
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: SMART CENTER BOSTON Business Location: 257 MCGRATH HWY Business Phone: 617-666-4100	
License Holder: HERB CHAMBERS I-93 INC 257 MCGRATH HWY SOMERVILLE MA 02143	
Mailing Address: HERB CHAMBERS I-93 INC 257 MCGRATH HWY SOMERVILLE MA 02143	
Business Type: Corporation HERBERT CHAMBERS HERBERT CHAMBERS BRUCE SPATZ	
FID: 061335996	
Emergency Contact: JEFF DAVIS Phone:	
Dealership Class: Class 1 # of Vehicles Kept Inside: 5 # of Vehicles Kept Outside: 5 Proposed Hours of Operation if operating outside standard hours: m-r 7-9 f 7-7 sa 8-5 su 11-5	

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: _____



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Herb Chambers I-93 Inc
Address of taxpayer/applicant's business in Somerville: 255 McCord Highway
Address of taxpayer/applicant's home in Somerville: _____
Taxpayer/applicant's phone: day: 617 666 4410 evening: _____

I, (print name) _____, 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 10th day of November, 20 15.

(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: _____

9922 # 145051001 # 789 # _____

NOTES:

CLERK'S INITIALS: SP

ORIGINAL STAMP:



The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Businesses

Applicant information:

Name: Herb Chambers I-SS Inc
Address: 255 Mc Crath Highway
City: Somerville State: MA Zip: 02143 Phone #: (617) 664 4102

- ☒ I am an employer with 110 employees (full and/or part time). Business Type: ☐ Retail
☐ I am a sole proprietor or partnership and have no employees. ☐ Restaurant/Bar/Eating Establishment
☐ We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. ☐ Office and/or Sales (real estate, auto, etc.)
☐ We are a nonprofit organization staffed by volunteers and have no employees. ☐ Nonprofit
☐ Entertainment
☐ Manufacturing
☐ Health Care
☐ Other _____

Workers' compensation insurance information (if applicable):

Insurance Company Name: Travelers Insurance
Address: 350 Granite St
City: Braintree State: MA Zip: 02126 Phone #: 508-319-5782
Policy #: C2KU31010254 Expiration Date: 10/1/16

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: [Signature] Date: 11/14/15

Print Name: Herbert Chambers

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 _____