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# 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: **150.00**
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**<br>Business Location: **40 HOLLAND ST**<br>Business Phone: **617-623-9601** | |
| License Holder: **ABP CORPORATION**<br>**AU BON PAIN**<br>**1 AU BON PAIN WAY**<br>**BOSTON, MA 02210**<br>**617-623-9601** | |
| Mailing Address: **ABP CORPORATION**<br>**AU BON PAIN**<br>**1 AU BON PAIN WAY**<br>**BOSTON, MA 02210** | |
| Business Type: **CORPORATION (INC. LLC)**<br>**SECRETARY - JOHN BILLINGSLEY**<br>**TREASURER - MICHAEL LYNCH**<br>**PRESIDENT - SUSAN MORELLI** | SECRETARY - TOM DOLAN |
| FID: **043466910** | |
| Food Manager/Emergency Contact:<br>**LAURA BETLOW** | 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: _____ Date 11-14-2013

Print Name: MARIO WATKINS Phone 617-897-5079

# IMPORTANT

**It's time to renew your Outdoor Seating and Goods license. We are converting to new software, and the enclosed page shows the information we have on file for your license. Please fill out that page AND the 6 boxes below with the correct information. Return all 4 pages with your fee and with evidence that 1) your $5,000 Licenses and Permits Bond remains in effect, OR 2) your business liability insurance lists the City as an Additional Insured. Call John Long, City Clerk, at 617 625-6600 x4110 if you have any questions.**

The DBA Name of the Business: Au Bon Pain

Somerville Address and Zip Code: 18-48 Holland Street, Somerville, MA. 02144

Phone Number of the Business: 617-623-9601

The Legal Name of the License Holder: ABP Corporation

Street Address of the License Holder: One Au Bon Pain Way

City, State and Zip Code of the License Holder: Boston, MA. 02210

Phone Number of the License Holder: 617-897-5079

Where We Should Send Mail: Name: ABP Corporation

Street Address: One Au Bon Pain Way

City, State and Zip Code: Boston, MA. 02210 ATTN: Mario Watkins

Federal ID # (Do Not Give a Social Security #): 04-3466910

Emergency Contact and his/her Phone Number: Sanjog Rana

Type of Business (Check Only One and Print the Names Indicated):

___ Sole Proprietor: Name of Owner:

___ Partnership (inc. LLP): Name of Partnership:

Names of All Partners Who Own More Than 10%:

___ Trust: Name of Trust:

Names of All Trustees Who Own More Than 10%:

✓ Corporation: Name of Corporation: ABP Corporation

Name of President: Susan Morelli

Name of Secretary: John Billingsley Name of Treasurer: Michael Lynch

___ LLC: Name of LLC:

Names of All Managers:

___ Other (Attach a Description of the Form of Ownership and the Names of the Owners)

**ACKNOWLEDGEMENT: 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 Somerville Licensing Commission.**
**-I have filed all State tax returns and paid all State taxes required by law for this business.**

License Holder Signature: [signature] Date 11-14-2013

CITY OF SOMERVILLE, MASSACHUSETTS
Treasury Department
JOSEPH A. CURTATONE
MAYOR

# CERTIFICATE OF GOOD STANDING

**PLEASE PRINT**

**NAME OF PERSON REQUESTING CERTIFICATE:** _____

**BUSINESS LOCATION:** 40 HOLLAND ST, SOMERVILLE, MA. 02144 **AND/OR**

**TAXPAYER'S HOME ADDRESS:** N/A

**TAXPAYER/APPLICANT PHONE: DAY:** 617-899-5099 **EVENING:** 617-623-9601

**BUSINESS NAME:** AU BON PAIN

**BUSINESS ID NUMBER:** 04-3466910 **BUSINESS PHONE:** 617-623-9601

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 to the City of Somerville 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 23RD day of MAY, 20 13. Mario Watkins (Taxpayer's Signature)

## CITY'S ACKNOWLEDGEMENT

**DATE OF ISSUANCE:** _____

**TAXES AND ACCOUNT NUMBER(S)**

| **REAL ESTATE ID | **WATER/SEWER ID | **PERSONAL PROPERTY | **OTHER |
|---|---|---|---|
| 7486 | 66107401 | 687 | |

**NOTES:**

**CLERKS INITIALS:** CA

**BUSINESS or BUILDING PERMIT** **ORIGINAL STAMP**

RECEIVED 5-23-13

311 SOMERVILLE

*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: Mario Watkins Date: 11-14-2013

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 #:*_____

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

*Contact Person:*_____ *Phone #:*_____

(revised Jan. 2008)

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/31/2013

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

101820--ALL-13-14 523

**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-003422288-33 **REVISION NUMBER:** 11

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-Z91-438380-033 | 08/01/2013 | 08/01/2014 | 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 | | | WA2-Z9D-438380-013 | 08/01/2013 | 08/01/2014 | X WC STATU-TORY LIMITS OTH-ER | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** | N/A | | | | | 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
City of Somerville, MA is 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.

**CERTIFICATE HOLDER**

Kadima Medical Properties, L.L.C.
P. O. Box 756
Mid-Town Post Office
New York, NY 10018

**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