

# APPLICATION FOR A SIGN OR AWNING OVER A PUBLIC WAY

Application Fee \$250.00

Date 9/5/13

2013 SEP - 5 2:02	
FOR CITY CLERK'S OFFICE ONLY	
Date Recorded	<u>CITY CLERK'S OFFICE</u>
Amount Paid	<u>SOMERVILLE, MA</u>

☒ New Sign, Awning or Advertising Device

☐ New Facing on an Existing Frame

☐ Renewing Existing Sign, Awning or Advertising Device Permit for a New Owner

Applicant's Legal Name: BRIGHT HORIZONS Phone: (617) 673-8105

Applicant's Address (with Zip Code): 200 TALCOTT AVE SOUTH WATER TOWN, MA 02472

Applicant's Email Address: J MONIN @ BRIGHT HORIZONS.COM

Applicant's Federal Employer Identification Number: 80-0188248

Business DBA Name (if applicable): BRIGHT HORIZONS

Business Location (with Zip Code): 99 DOVER ST

Mailing Name (where we should send correspondence to): BRIGHT HORIZONS - JARAD MONIN

Mailing Address (with Zip Code): 99 DOVER ST SOMERVILLE MA

Emergency Contact: JARAD MONIN Phone: (617) 673-8105

Type of Business (Check one): ☐ Sole Proprietor ☐ Partnership (inc. LLP) ☐ Trust  
☒ Corporation (inc. LLC) ☐ Other

## IF A SOLE PROPRIETOR:

Owner's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

## IF A PARTNERSHIP, TRUST OR CORPORATION (Attach additional sheets as needed):

Partner's/Member's/President's Name: \_\_\_\_\_

~~Address with Zip Code:~~ \_\_\_\_\_

Partner's/Member's/Secretary's Name: \_\_\_\_\_

~~Address with Zip Code:~~ \_\_\_\_\_

Partner's/Member's/Treasurer's Name: \_\_\_\_\_

~~Address with Zip Code:~~ \_\_\_\_\_

Name of company erecting sign: SERVICE SELECT LLC / ARNCO SIGN

Phone: (215) 758-7588

Detailed description and location of the sign, awning, or advertising device. Attach a sketch. ☒

ATTACH NON ILLUMINATED LETTERS TO REAR OF BUILDING  
FACING MEACHAM ST

#### ACKNOWLEDGEMENT

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this permit. This permit will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville.

Signature of Applicant: Donna M. Cullen Date: 8/21/13

Print Name: DONNA M. CULLEN Phone: (508) 380-5725

#### INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:

This sign or awning is located in a historic district: ☐ True ☒ False

Based on a review of the attached plans, I reasonably expect that this sign, awning, or advertising device will conform to all ordinances and the State Building Code. (NOTE: This statement does NOT constitute permission to install the sign, awning, or advertising device.)

Signature: Al Bargo Date: 8-21-13

Print Name: Al Bargo Title: L.B.I.

#### HISTORIC PRESERVATION COMMISSION RECOMMENDATION:

(only required for signs or awnings in a historic district)

The Historic Preservation Commission recommends ☐ Approval ☐ Denial

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_







**PROPOSED SITE PLAN**

**SCOPE OF WORK**

① NON-ILLUMINATED FOOT LETTERS



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
8/29/2013

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).

<b>PRODUCER</b> R. W. Squeri Agency Inc. 698 Main Street  Branford CT 06405		<b>CONTACT NAME:</b> Gerry Mann <b>PHONE (A/C, No. Ext):</b> (203) 488-1677 <b>FAX (A/C, No.):</b> (203) 481-8541 <b>E-MAIL ADDRESS:</b> gmann@squeri.com															
<b>INSURED</b> Arnco Sign Company, Inc. 1133 South Broad Street  Wallingford CT 06492		<table border="1"><thead><tr><th>INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr></thead><tbody><tr><td>INSURER A: Peerless Insurance</td><td>24198</td></tr><tr><td>INSURER B: The Netherlands Ins CO</td><td>24171</td></tr><tr><td>INSURER C: Peerless Indemnity Ins CO</td><td>18333</td></tr><tr><td>INSURER D:</td><td></td></tr><tr><td>INSURER E:</td><td></td></tr><tr><td>INSURER F:</td><td></td></tr></tbody></table>		INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: Peerless Insurance	24198	INSURER B: The Netherlands Ins CO	24171	INSURER C: Peerless Indemnity Ins CO	18333	INSURER D:		INSURER E:		INSURER F:	
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## COVERAGES

CERTIFICATE NUMBER: CL1371901251

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	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY			CBP8911667	7/22/2013	7/22/2014	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 5,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY \$ 1,000,000
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						GENERAL AGGREGATE \$ 2,000,000
B	AUTOMOBILE LIABILITY			BA8301866	7/22/2013	7/22/2014	PRODUCTS - COMP/OP AGG \$ 2,000,000
	<input type="checkbox"/> ANY AUTO						
	<input checked="" type="checkbox"/> ALL OWNED AUTOS	<input checked="" type="checkbox"/> SCHEDULED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> HIRED AUTOS	<input checked="" type="checkbox"/> NON-OWNED AUTOS					BODILY INJURY (Per person) \$
A	UMBRELLA LIAB	<input checked="" type="checkbox"/> OCCUR		CU8309466	7/22/2013	7/22/2014	BODILY INJURY (Per accident) \$
	EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE					PROPERTY DAMAGE (Per accident) \$
	DED	RETENTION \$					Medical payments \$ 5,000
							EACH OCCURRENCE \$ 1,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WC8309258	7/22/2013	7/22/2014	AGGREGATE \$ 1,000,000
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N	N/A				
	If yes, describe under DESCRIPTION OF OPERATIONS below						<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER
							E.L. EACH ACCIDENT \$ 500,000
							E.L. DISEASE - EA EMPLOYEE \$ 500,000
							E.L. DISEASE - POLICY LIMIT \$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)  
RE: Site ID: SS#52432 Bright Horizons-Davis Square, Somerville, MA

Additional Insured: City of Somerville, Somerville, MA

## CERTIFICATE HOLDER

## CANCELLATION

City of Somerville  
93 Highland Ave.  
Somerville, MA 02143

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

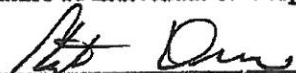
Gerry Mann/GM

**MASSACHUSETTS DEPARTMENT OF REVENUE  
REVENUE ENFORCEMENT AND PROTECTION (REAP)  
ATTESTATION**

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all State tax returns and paid all State taxes required under law.

BRIGHT HORIZONS CAPITAL CORP, BRIGHT HORIZONS CHILDREN'S CONTINUS LLC

\*Signature of Individual or Corporate Name (Mandatory)



By: Corporate Officer (Mandatory, if a corporation)

80-0188248

\*\*Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

\* This license will not be issued unless this certification clause is signed by the applicant.

\*\* Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.





City of Somerville, Massachusetts  
Finance Department, Treasury Division

**WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.**

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: BRIGHT HORIZONS

Address of taxpayer/applicant's business in Somerville: 99 DOVER ST.

Address of taxpayer/applicant's home in Somerville: \_\_\_\_\_

Taxpayer/applicant's phone: day: \_\_\_\_\_ evening: \_\_\_\_\_

I, (print name) Donna Cullen - Agent, 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 21<sup>st</sup> day of

AUGUST, 2013. Donna Cullen - agent  
(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: \_\_\_\_\_

# 4715 # 322064011 # 389 # \_\_\_\_\_

NOTES:

CLERK'S INITIALS: URB

ORIGINAL STAMP:



RECEIVED  
URB

8-21-13

**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: SCAVIER SELECT ARNCO SIGN  
Address: 400 MAVER DR 1133 S BROAD ST  
City: WALLINGFORD CT State: CT Zip: 06492 Phone #: (203) 788-3898

- ☒ I am an employer with 50 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 DAY CARE

**Workers' compensation insurance information (if applicable):**

X Insurance Company Name: PEBR LOSS INDEMNITY INS  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
X Policy #: WC 8309258 Expiration Date: 7/22/14

**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: Donna M. Cullen Date: 9/5/13  
Print Name: DONNA M. CULLEN

**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  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ ☐ Other \_\_\_\_\_