

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

PAST DUE

Application to Renew Garage License

JOHN MATTHEWS
P.O. BOX 238
MEDFORD MA 02155

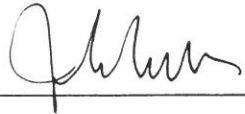
License #: BL15-000750
File #: 15-633
Fee: 550

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: JOHN MATTHEWS Business Location: 9 R SHERMAN ST Business Phone: 781-483-3360	
License Holder: JOHN MATTHEWS P.O. BOX 238 MEDFORD MA 02155	
Mailing Address: JOHN MATTHEWS P.O. BOX 238 MEDFORD MA 02155	
Business Type: Corporation JOHN MATTHEWS JOHN MATTHEWS JOHN MATTHEWS	
FID: 042974372	
Emergency Contact: JOHN MATTHEWS Phone: 617-389-2065	781-389-2065
Proposed Hours of Operation if outside standard hours: MO-FR 7AM-7PM, SA 8AM-5PM # of Vehicles Kept Inside: 0 # of Vehicles Kept Outside: 0 Open to the public? Yes Mechanical repairs? Yes Autobody work? No Spray Painting? No Washing vehicles? No Charging money to store vehicles? No Storing unregistered vehicles? No Maintaining or operating a tow vehicle at this location? No	

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: 11/4/15

Printed Name: John Matthew Phone: 781-389-2565



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: U Call We Haul

Address of taxpayer/applicant's business in Somerville: 98 Sherman St.

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

Taxpayer/applicant's phone: day: 781-389-2065 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 15 day of

November, 2015. _____
(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: _____

13882 # N/A # _____ # _____

NOTES:

CLERK'S INITIALS: UB

ORIGINAL STAMP: **received**
(Berman)
1-14-16

**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: John Matthews
 Address: P.O. Box 238
 City: MEDFORD State: MA Zip: 02155 Phone #: 781-389-2065

- | | | |
|--|----------------|--|
| <input type="checkbox"/> I am an employer with <u>12</u> employees (full and/or part time). | Business Type: | <input type="checkbox"/> Retail |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees. | | <input type="checkbox"/> Restaurant/Bar/Eating Establishment |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. | | <input type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees. | | <input type="checkbox"/> Nonprofit |
| | | <input type="checkbox"/> Entertainment |
| | | <input type="checkbox"/> Manufacturing |
| | | <input type="checkbox"/> Health Care |
| | | <input type="checkbox"/> Other _____ |

Workers' compensation insurance information (if applicable):

Insurance Company Name: A. GANJE & SONS INC
 Address: 376 Main St.
 City: MEDFORD State: MA Zip: 02155 Phone #: 781-396-3111
 Policy #: WC 231538526015 Expiration Date: 3/23/2016

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: 11/4/15
 Print Name: John Matthew

Official use only. Do not write in this area. To be completed by city or town official.

City or Town: _____ Permit/License #: _____

<input type="checkbox"/>	Board of Health
<input type="checkbox"/>	Building Department
<input type="checkbox"/>	City/Town Clerk
<input type="checkbox"/>	Licensing Board
<input type="checkbox"/>	Selectmen's Office
<input type="checkbox"/>	Other _____

Contact Person: _____ Phone #: _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

10/08/2015

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 A. GANGE & SONS INC. P.O. BOX 301 MEDFORD MA 02155		CONTACT NAME: Mary Mui PHONE (A/C, No, Ext): (781) 396-3111 E-MAIL ADDRESS: mmui@gange-insurance.com	FAX (A/C, No):
INSURED U CALL WE HAUL LLC PO BOX 238 MEDFORD MA 02155		INSURER(S) AFFORDING COVERAGE INSURER A: LIBERTY MUTUAL FIRE INS CO INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	NAIC # 23035

COVERAGES

CERTIFICATE NUMBER: 4334

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 SUBR INSD WYD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:		N/A			EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS		N/A			COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$		N/A			EACH OCCURRENCE \$ AGGREGATE \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N/A	N/A N/A WC231S385260015	03/03/2015	03/03/2016	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
			N/A			

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Workers' Compensation benefits will be paid to Massachusetts employees only. Pursuant to Endorsement WC 20 03 06 B, no authorization is given to pay claims for benefits to employees in states other than Massachusetts if the insured hires, or has hired those employees outside of Massachusetts.

This certificate of insurance shows the policy in force on the date that this certificate was issued (unless the expiration date on the above policy precedes the issue date of this certificate of insurance). The status of this coverage can be monitored daily by accessing the Proof of Coverage - Coverage Verification Search tool at www.mass.gov/lwd/workers-compensation/investigations/.

CERTIFICATE HOLDER

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

Daniel M. Crowley
Daniel M. Crowley, CPCU, Vice President - Residual Market - WCRBMA

MA 02143