

IMPORTANT

Dear License Holder:

It is time to renew the license issued by the Somerville Board of Aldermen. We are converting to a new software system, and you will see below the information we have on file for your license. Please fill out all six boxes below with the correct information so we can update our records, and return all of the pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

License Type: Outdoor Parking

License Number: #191424

Business Name: Star Market #7575

Location: 275 Beacon St

Spaces: 3

Special Conditions (if any):

Renewal Fee (Return with this application): \$20 per Space

2012 APR 23 PM 4: 21
CITY CLERK'S OFFICE
CITY OF SOMERVILLE, MA

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business:	Star Market (#7575)
Somerville Address and Zip Code:	275 Beacon St 02145
Phone Number of the Business:	617-354-7023

The Legal Name of the License Holder:	Star Markets, Inc
Street Address of the License Holder:	250 Parkcenter Blvd
City, State and Zip Code of the License Holder:	Boise, ID 83726
Phone Number of the License Holder:	208-395-4913
Email Address of the License Holder:	licensegroup@supervalu.com

Where We Should Send Mail: Name:	Supervalu
Street Address:	250 Parkcenter Blvd
City, State and Zip Code:	Boise, ID 83726 Attn: Licensing
Email:	licensegroup@supervalu.com
Phone Number:	208-395-4913

Federal ID # (Do Not Give a Social Security #):	04-3243710
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Emergency Contact and Phone (For Fire Dept. Use):	Marty O'Halloran 617-354-7023
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-OVER-

APR 12 2012
RECORDED ON
STORE SUPPORT CENTER

RECEIVED MAR 30 2011

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

 Sole Proprietor: Name of Owner: _____

 Partnership (inc. LLP): Names of All Partners Who Own More Than 10%: _____

 Trust: Names of All Trustees Who Own More Than 10%: _____

☒ Corporation (inc. LLC): Name of President: Michael Stigers

Name of Secretary: Carol Wood

Name of Treasurer: John Boyd

 Other (Attach a Description of the Form of Ownership and the Names of 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 Board of Aldermen.

-I have filed all State tax returns and paid all State taxes required by law for this business.

License Holder Signature: Deborah Sunderland Date 4/12/12



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Star Market

Address of taxpayer/applicant's business in Somerville: 275 Beacon St

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

Taxpayer/applicant's phone: day: 208-395-4913 evening: N/A

I, (print name) Deborah Sunderland, 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 12th day of April, 20 12. Deborah Sunderland
(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: _____

19633165
1125 # 661052001 # 46 # _____

NOTES:

CLERK'S INITIALS: M.M.

ORIGINAL STAMP:



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: Star Market
Address: 275 Beacon St.
City: Somerville State: MA Zip: 02145 Phone #: 617-354-7023

- ☒ I am an employer with 100+ 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: Deborah Sunderland Date: 4/12/12
Print Name: Deborah Sunderland

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 _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
08/04/2011

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. 333 South 7th Street, Suite 1600 Minneapolis, MN 55402-2400 Attn: MinneapolisCertRequest@marsh.com/fax: 212-948-0700 067800-STND2-GAWXS-11-12	CONTACT NAME: PHONE (A/C, No. Ext): E-MAIL ADDRESS:	FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE	
INSURED SUPERVALU INC. ITS AFFILIATES AND SUBSIDIARIES P.O. BOX 990 MINNEAPOLIS, MN 55440	INSURER A: Old Republic Insurance Co	NAIC # 24147
	INSURER B: National Union Fire Ins Co Pittsburgh PA	19445
	INSURER C: SAFETY NATIONAL CASUALTY CORPORATION	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES**CERTIFICATE NUMBER:**

CHI-004171608-28

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 <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> \$1,000,000 SIR <input checked="" type="checkbox"/> Erodes Each Occ limit GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC			MWZY59237	08/01/2011	08/01/2012	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ -0- PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COM/OP AGG \$ 4,000,000 \$
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS			MWTT13061	08/01/2011	08/01/2012	COMBINED SINGLE LIMIT (Ea accident) \$ 5,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$			25030442	08/01/2011	08/01/2012	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
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 <input checked="" type="checkbox"/> N	N/A	MWC11707900	08/01/2011	08/01/2012	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000
C	EXCESS WORKERS COMP.			SP4044706 *See Additional Page*	08/01/2011	08/01/2012	EACH ACCIDENT 1,000,000 DISEASE - EACH EMPLOYEE 1,000,000

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

FOR EVIDENCE PURPOSES ONLY

CERTIFICATE HOLDER**CANCELLATION**

SUPERVALU INC. ITS AFFILIATES AND SUBSIDIARIES P.O. BOX 990 MINNEAPOLIS, MN 55440	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 <i>Manashi Mukherjee</i>

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