CITY OF SOMERVILLE

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

Application to Renew Garage License

LEINS AUTO REPAIR INC.
65 BOW ST
SOMERVILLE MA 02143

License #: BL15-000591
File #: 15-479
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: LEINS AUTO REPAIR INC. **Business Location:** 69 BOW ST **Business Phone:** 617-623-9000	
License Holder: LEINS AUTO REPAIR INC. 65 BOW ST SOMERVILLE MA 02143	
Mailing Address: LEINS AUTO REPAIR INC. 65 BOW ST SOMERVILLE MA 02143	
Business Type: Corporation LUIS LEINS LUIS LIENS LUIS LEINS	
FID: 542080683	
Emergency Contact: LUIS LEINS **Phone:**	
Proposed Hours of Operation if outside standared hours: MO-FR 8AM-6PM, SA 8AM-2PM **# of Vehicles Kept Inside:** 2 **# of Vehicles Kept Outside:** 8 **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	

2015 MAR 24 P 1:55
CITY CLERK'S OFFICE
SOMERVILLE, MA

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: 3-24-15

Printed Name: Luis Leins Phone: 617-623-9000

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Lains Auto Repair Inc.

Address of taxpayer/applicant's business in Somerville: 69-71 Bow St.

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

Taxpayer/applicant's phone: day: 617-623-9000 evening: 617-623-1390

I, (print name) Luis Lains, 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 24 day of March, 2015. _____
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: 3-24-15 **INCLUDES RELEVANT POSTINGS THROUGH:** _____

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate	☐ Water/Sewer	☐ Personal Property	☐ Other: ___
# 1850	#232058001	# 77	#

NOTES:

CLERK'S INITIALS: JK **ORIGINAL STAMP:** PAID 3-24-15

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: Lains Auto Repair Inc.

Address: 65 1/2 Bow St

City: Somerville State: MA Zip: 02143 Phone #: 617-623-9000

- ☐ 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: Utica National Insurance Group.

Address: 180 Genesee St.

City: New Hartford State: NY Zip: 13413 Phone #:

Policy #: 4265993 Expiration Date: 11-25-15

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: _____ Date: 3-24-15

Print Name: _____

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)

UTICA NATIONAL INSURANCE GROUP
180 Genesee Street
New Hartford, NY 13413

Issuing Company: Graphic Arts Mutual Insurance Company
MEMBER OF UTICA NATIONAL INSURANCE GROUP

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Information Page

Policy Number: 4265993

Prior Policy Number:

1. **The Insured and Mailing Address:**
LEINS AUTO REPAIR, INC.
65 1/2 BOW STREET
SOMERVILLE MA 02143

Producer: Prescott & Son Ins Agcy
963 Eastern Avenue
Malden, MA 02148

Entity of Insured: Corporation

Producer Number: 70164

SIC#: 55211

Other workplaces not shown above:

Insured's I.D. Number: 542080683
Risk I.D. Number: MA: 000173165

NCCI Company Number: 15822

2. **The policy period is from** 11/25/2014 **to** 11/25/2015 **12:01 AM Standard Time at the insured's mailing address.**

3. A. **Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:** Massachusetts

B. **Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:**

Bodily Injury by Accident	$ $500,000	Each Accident
Bodily Injury by Disease	$ $500,000	Policy Limit
Bodily Injury by Disease	$ $500,000	Each Employee

C. **Other States Insurance: Part Three of the policy applies to the states, if any, listed here:**

All States except those listed in Item 3.A., ND, OH, WA, WY

D. **This policy includes these endorsements and schedules:**

4. **The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.**

☐ See Extension of Information Page Classifications	Code No.	Premium Basis Total est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Minimum Premium: $ 273 MA	**Expense Constant**	$
Employer's Liab Minimum Premium: $	**Total Estimated Annual Premium**	$ 1,946
If indicated below, interim adjustments of premium shall be made:	**Deposit Premium**	$ 1,946

Issuing Office:

8-D-WC Ed. 08-2008
UNIBILL NO 100813251

Date of Issue: 09-11-2014

Countersigned by John A. Giffin