



**CITY OF SOMERVILLE
BOARD OF ALDERMEN**
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143
(617) 625-6600

Ch-2916
\$1100

2012

APPLICATION TO RENEW FLAMMABLES LICENSE

RAFAEL E. CASTILLO
141 MIDDLESEX AVENUE
MEDFORD, MA 02155

License #: 900

City #F90

Fee: 550.00

Account ID: 618

Reference #: 900

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: For GOOD GAS SOMERVILLE Business Location: 343 MEDFORD ST Business Phone: 617-776-0590	
License Holder: PCJ AUTO SERVICES, INC. D/B/A GOOD GAS SOMERVILLE 00343 -00345 MEDFORD ST SOMERVILLE, MA 02145 617-776-0590	
Mailing Address: RAFAEL E. CASTILLO MEDFORD, MA 02155	
Business Type: CORPORATION (INC. LLC)	
FID: 261691140	
Food Manager/Emergency Contact:	

2013 APR 23 PM 3:45
CITY CLERK'S OFFICE
SOMERVILLE, MA

Conditions: (to change any conditions, submit a new application. Contact the City Clerk's Office for more information)

Hours: **MO-SU 5 AM - MIDNIGHT**

Description of Location and/or Other Conditions:

Originally Issued 9/9/1937, Amended 09/25/75, 7/9/97. 20,000 Gals. Gasoline. 500 Gals. Oil.

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: *Rafael E. Castillo* Date: 4-23-13

Print Name: RAFAEL E CASTILLO Phone: 617 776 0590

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: GOOD GAS INC
Address: 345 MEDFORD ST.
City: LOWELLVILLE State: MA Zip: 02143 Phone #: 617 776 0590

- | | | |
|--|--|--|
| <input type="checkbox"/> I am an employer with _____ 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: _____
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: *Rafael Castillo* Date: 4-23-13
Print Name: RAFAEL CASTILLO
SEE ATARI

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
Contact Person: _____	Phone #: _____	<input type="checkbox"/> Other _____



CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)
 4/25/2013

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 O'DONOGHUE INS AGENCY INC 90 Summer Street P.O. Box 181 Arlington MA 02476		CONTACT NAME: Diane Newton PHONE (A/C No. Ext): (781) 646-9300 FAX (A/C No.): (781) 646-1546 E-MAIL ADDRESS:	
INSURED PCJ Auto Rafael Castillo 345 Medford St Somerville MA 02143		INSURER(S) AFFORDING COVERAGE INSURER A: Travelers Property & Casualty INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES

CERTIFICATE NUMBER: CL1342513353

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 INSR WVR	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> 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"/> PROJECT <input type="checkbox"/> LOC					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"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					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 <input type="checkbox"/> RETENTION \$					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 <input type="checkbox"/> N/A	UB3460R15612	7/31/2012	7/31/2013	WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ 100,000 E.L. DISEASE - EA EMPLOYEE \$ 100,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

CERTIFICATE HOLDER

CANCELLATION

 City of Somerville
 Somerville, MA

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

K O'Donoghue/Diane



CITY OF SOMERVILLE, MASSACHUSETTS

Treasury Department

JOSEPH A. CURTATONE

MAYOR

CERTIFICATE OF GOOD STANDING

PLEASE PRINT

NAME OF PERSON REQUESTING CERTIFICATE: _____

BUSINESS LOCATION: 345 MEDFORD ST. AND/OR

TAXPAYER'S HOME ADDRESS: 141 MIDDLESEX.

TAXPAYER/APPLICANT PHONE: DAY: _____ EVENING: _____

BUSINESS NAME: _____

BUSINESS ID NUMBER: _____ BUSINESS PHONE: _____

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 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 _____ day of _____,

20_____. _____ (Taxpayer's Signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____

TAXES AND ACCOUNT NUMBER(S)

**REAL ESTATE ID

9801

**WATER/SEWER ID

208001001

**PERSONAL PROPERTY

834

**OTHER _____

NOTES:

CLERKS INITIALS: UB

BUSINESS or BUILDING
PERMIT

ORIGINAL STAMP

