

1-12-10

APPLICATION FOR A SIGN OR AWNING OVER A PUBLIC WAY

Application Fee \$250.00

Date 12/27/11

FOR CITY CLERK'S OFFICE ONLY

Date Recorded 1-4-12

Amount Paid 250.00

☒ 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: Christopher Kokoras Insurance Agency Inc. Phone: 617 775 7990

Applicant's Address (with Zip Code): 272 Broadway Som, MA 02145

Applicant's Email Address: chris.koko@verizon.net

Applicant's Federal Employer Identification Number: 043423546

Business DBA Name (if applicable):

Business Location (with Zip Code):

Mailing Name (where we should send correspondence to): CHRISTOPHER KOKORAS 187 Westminister Ave

Mailing Address (with Zip Code): WATERTOWN MA 02472

Emergency Contact: ANNE BATES MGR. Phone: 617 775-7990

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: CHRISTOPHER KOKORAS

Address with Zip Code: 187 Westminister Ave Watertown MA 02472

Partner's/Member's/Secretary's Name: Christopher Kokoras

Address with Zip Code: same

Partner's/Member's/Treasurer's Name: CHRISTOPHER KOKORAS

Address with Zip Code: same

Name of company erecting sign: Hunter Signs
Phone: 617 775 7990 (ext)

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

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: Anna Bates Date: 12/27/11

Print Name: Anna Bates Phone: 617 775-7990
Manager Christopher K...

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: [Signature] Date: 12-30-11
Print Name: Leo J. Kravtsov Title: Chief Insp

HISTORIC PRESERVATION COMMISSION RECOMMENDATION:

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

The Historic Preservation Commission recommends Approval ☐ Denial ☐

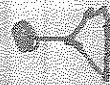
Signature: _____ Date: _____

Print Name: _____ Title: _____

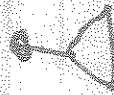
SHOP DRAWING

LIGHT FIX WILL BE
ATTACHED TO STONE
PER THE ELECTRICAL CODE
BY SOME LOPS ESCOBA

PL



Christopher Kokoras
Insurance Agency



9'

attached to building with anchor bolts
& L brackets

CITY OF SOMERVILLE
INSPECTOR'S SERVICES DIVISION
STANLEY ROAD
SOMERVILLE, MA 02145
PR 11-864
12-31-11

Luk

Christopher Kokoras
Insurance Agency

2'x9'x1" aluminum framed sign hunter green with white lettering

NOTICE: PRINTS ARE EXCLUSIVE PROPERTY OF HUNTER SIGNS INC. ANY UNAUTHORIZED USE OR DUPLICATION WILL RESULT IN A 20% CHARGE PER OCCURRENCE PER THE VALUE OF THE DISPLAY

Customer: Chris Kokoras
Company: Christopher Kokoras Insurance Agency
Address: 272 Broadway st.
City: Somerville
Phone: 617-776-7990
Fax:

Hunter SIGNS
120 Business St. Hyde Park, MA 02136
Ph: 617-360-9710 Fax: 617-360-9711
email: huntersigns@ron.com

Job No.:	Date: 12/27/11
Order Date:	Salesperson: Fred Hunter
Sign Dimensions: 2'x9'x1" aluminum framed sign bronze with white vinyl letters	Estimate: \$715.00
Comments:	



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

12/30/11

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 H & K Ins. Agency, Inc. P.O. Box 344 182 Main Street Watertown, MA 02472	CONTACT NAME: PHONE (A/C No Ext): (617) 924-5600 FAX (A/C No): (617) 926-0912 E-MAIL ADDRESS: info@hkinsurance.com																					
INSURED Christopher Kokoras Insurance Agency Inc. 187 Westminister Ave Watertown, MA 02472	<table border="1"><tr><th colspan="2">INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr><tr><td>INSURER A:</td><td>CNA Commercial Insurance</td><td></td></tr><tr><td>INSURER B:</td><td></td><td></td></tr><tr><td>INSURER C:</td><td></td><td></td></tr><tr><td>INSURER D:</td><td></td><td></td></tr><tr><td>INSURER E:</td><td></td><td></td></tr><tr><td>INSURER F:</td><td></td><td></td></tr></table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	CNA Commercial Insurance		INSURER B:			INSURER C:			INSURER D:			INSURER E:			INSURER F:		
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COVERAGES**CERTIFICATE NUMBER:****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 WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY		2084748818	4/22/11	4/22/12	EACH OCCURRENCE \$ 2,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY					DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR					MED EXP (Any one person) \$ 10,000
	GEN'L AGGREGATE LIMIT APPLIES PER					PERSONAL & ADV INJURY \$ 2,000,000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC					GENERAL AGGREGATE \$ 4,000,000
	AUTOMOBILE LIABILITY					PRODUCTS - COMP/OP AGG \$ 4,000,000
	ANY AUTO					
	ALL OWNED AUTOS	SCHEDULED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$
	HIRED AUTOS	NON-OWNED AUTOS				BODILY INJURY (Per person) \$
						BODILY INJURY (Per accident) \$
						PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB	<input type="checkbox"/> OCCUR	B2090314359	4/22/11	4/22/12	EACH OCCURRENCE \$ 5,000,000
	<input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$ 5,000,000
	DED RETENTION \$					
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	Y/N	2084748852	4/22/11	4/22/12	WC STATUTORY LIMITS OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> N/A				E.L. EACH ACCIDENT \$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below					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)

City of Somerville Named as Additional Insured

CERTIFICATE HOLDER**CANCELLATION**

City of Somerville	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 John R. Herlihy

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ACORD 25 (2010/05)

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Phone:

Fax:

E-Mail:

**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.

Christopher Kokoras Insurance Agency Inc.
*Signature of Individual or Corporate Name (Mandatory)

Christopher Kokoras Chris Kokoras President
By: Corporate Officer (Mandatory, if a corporation)

04 342 354 6
**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: Christopher Kokoras Insurance Agency I

Address of taxpayer/applicant's business in Somerville: 272 Broadway

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

Taxpayer/applicant's phone: day: 617 775 7990 evening: 617 775 7990

I, (print name) Christopher Kokoras, 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 31 day of

December, 20 11. Christopher Kokoras
(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: _____

134 61119 # NO WATER # _____ # _____

NOTES: 2005

CLERK'S INITIALS: _____

ORIGINAL STAMP: _____

RECEIVED
4-1-12
12



The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street, 7th Floor
Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Businesses

Applicant Information:

Please PRINT legibly

name: Christopher Kokoras Ins Agency Inc.
address: 272 Broadway
city: Som. state: MA zip: 02445 phone # 617 775-7990

work site location (full address):

- ☐ I am a sole proprietor and have no one working in any capacity. **Business Type:** ☐ Retail ☐ Restaurant/Bar/Eating Establishment
☐ Office ☐ Sales (including Real Estate, Autos etc.)
☒ I am an employer with 2 employees (full & part time). ☐ Other
☐ I am an employer providing workers' compensation for my employees working on this job.

company name:

address:

city:

phone #:

insurance co. See Attached

policy #

- ☐ I am a sole proprietor and have hired the independent contractors listed below who have the following workers' compensation policies:

company name:

address:

city:

phone #:

insurance co.

policy #

company name:

address:

city:

phone #:

insurance co.

policy #

Attach additional sheet if necessary

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 Anne Bates agent manager Date ✓ 1-4-12
Print name ✓ Anne Bates, Agr. Phone # ✓ 775-7990

official use only do not write in this area to be completed by city or town official

city or town: _____ permit/license # _____

☐ check if immediate response is required

contact person: _____ phone #: _____

(revised Sept. 2003)

- ☐ Building Department
☐ Licensing Board
☐ Selectmen's Office
☐ Health Department
☐ Other



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	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS HIRED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB EXCESS LIAB DED RETENTION \$		B2090314359	4/22/11	4/22/12	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	2084748852	4/22/11	4/22/12	WC STATUTORY LIMITS EL EACH ACCIDENT \$ 500,000 EL DISEASE - EA EMPLOYEE \$ 500,000 EL DISEASE - POLICY LIMIT \$ 500,000

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AUTHORIZED REPRESENTATIVE

John R. Herlihy

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