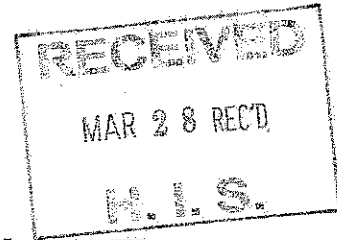


**IMPORTANT**



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: Livery  
License Number: #190883  
Business Name: Holiday Inn Somerville  
Location: 30 Washington St  
Vehicles: 1  
Special Conditions (if any):

Renewal Fee (Return with this application): \$100

2012 MAY 24 P 12:05  
CITY CLERK'S OFFICE  
SOMERVILLE, MA

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business: HOLIDAY INN  
Somerville Address and Zip Code: 30 WASHINGTON STREET 02143  
Phone Number of the Business: (617) 628-1000

The Legal Name of the License Holder: DDH HOTEL SOMERVILLE, LLC  
Street Address of the License Holder: 319 SPEEN STREET  
City, State and Zip Code of the License Holder: NATICK, MA 01760  
Phone Number of the License Holder: (508) 651-8300  
Email Address of the License Holder: DSHAMDIAN@DISTINCTIVEHOSPITALITYGROUP.COM

Where We Should Send Mail: Name: DAVID SHAMDIAN  
Street Address: 319 SPEEN STREET  
City, State and Zip Code: NATICK, MA 01760  
Email: DSHAMDIAN@DISTINCTIVEHOSPITALITYGROUP.COM  
Phone Number: (508) 651-8300

Federal ID # (Do Not Give a Social Security #): 27-2167407

Emergency Contact and Phone (For Fire Dept. Use): JIM HARVEY (617) 628-1000

-OVER-

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: \_\_\_\_\_

Name of Secretary: \_\_\_\_\_

Name of Treasurer: \_\_\_\_\_

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:** \_\_\_\_\_ **Date** \_\_\_\_\_



City of Somerville, Massachusetts  
Finance Department, Treasury Division

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: DDH HOTEL SOMERVILLE LLC

Address of taxpayer/applicant's business in Somerville: 30 WASHINGTON ST.

Address of taxpayer/applicant's home in Somerville: \_\_\_\_\_

Taxpayer/applicant's phone: day: (508) 651-8300 evening: (617) 628-1000

I, (print name) DAVID SHAMDIAN, 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 \_\_\_\_\_ day of

\_\_\_\_\_, 20 \_\_\_\_\_

(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: \_\_\_\_\_

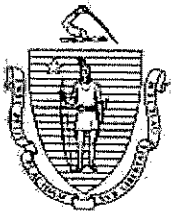
# 14497136      # 66/0022001      # 1301      # \_\_\_\_\_

NOTES: 15451

CLERK'S INITIALS: A

ORIGINAL STAMP:

**RECEIVED**  
A 5-24-12



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Print Form

Workers' Compensation Insurance Affidavit: General Businesses

**Applicant Information**

Please Print Legibly

Business/Organization Name: DDH Hotel Somerville LLC

Address: Holiday Inn, 30 Washington Street

City/State/Zip: Somerville, MA 02143

Phone #: 617-628-1000

<p><b>Are you an employer? Check the appropriate box:</b></p> <p>1. <input checked="" type="checkbox"/> I am an employer with <u>90</u> employees (full and/or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]</p> <p>3. <input type="checkbox"/> We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p><b>Business Type (required):</b></p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input checked="" type="checkbox"/> Other <u>full service hotel</u></p>
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\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

\*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

*I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.*

Insurance Company Name: Philadelphia Insurance Company

Insurer's Address: Michael A. Auricchio, Inc, 3800 Seneca Street

City/State/Zip: West Seneca, NY 14224-3478

Policy # or Self-ins. Lic. #: PH-UB-7206X81-0-11

Expiration Date: 4/28/12

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance 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: 4/19/12

Phone #: 508-651-8350

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

City or Town: \_\_\_\_\_ Permit/License # \_\_\_\_\_

Issuing Authority (circle one):

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office  
 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_