APPLICATION FOR A SIGN OR AWNING OVER A PUBLIC WAY

Application Fee $250.00

Date 5/12/12

FOR CITY CLERK'S OFFICE ONLY
Date Recorded
Amount Paid

✓ New Sign, Awning or Advertising Device

__ New Facing on an Existing Frame

__ Renewing Existing Sign, Awning or Advertising Device Permit for a New Owner

Business Name: Smiles By Rosie Inc. Phone: (617) 623-2100

Business DBA Name (if applicable):

Address with Zip Code: 6 Kensington Ave Somerville MA 02145

Tax Identification Number: 45-4650934 Check one: __ SSN ✓ FEIN

Mailing Name (where we should send correspondence to): Same

Address with Zip Code:

Property Owner Name: George Hatzis Phone: (617) 970-3899

Address with Zip Code: 136A West Adams st Somerville 02144

Emergency Contact 1: Will Wagner Phone: (413) 478-6341

Emergency Contact 2: Katie-Rose Wagner Phone: (413) 329-8756

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: KATIE-ROSE WAGNER

Address with Zip Code:

Partner's/Member's/Secretary's Name: "

Address with Zip Code:

Partner's/Member's/Treasurer's Name: "

Address with Zip Code:

Name of company erecting sign: Signarama

Phone: (508) 660-1231

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

FRONT - DIMENSIONAL letters 36X75

SIDE - MDO 40X72

BACK - MDO 40X84

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: [signature] Date: 5/11/12

Print Name: Katie-Rose Wagner Phone: (413) 329-8756

INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:

The Inspectional Services Department recommends: ✓ Approval ____ Denial

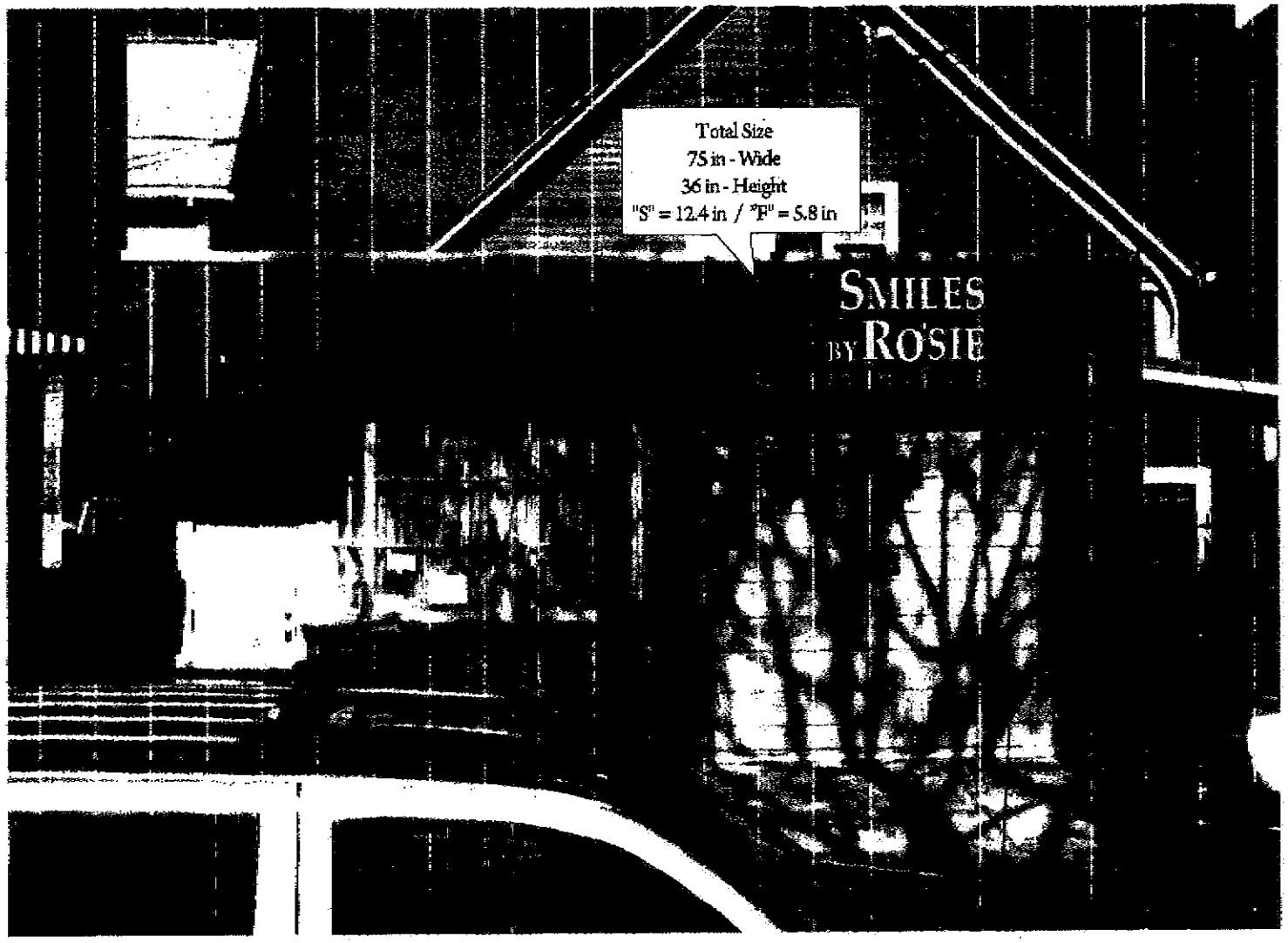
This sign or awning is to be installed in a historic district: ____ True ✓ False

Signature: [signature] Date: 6/13/12

HISTORIC PRESERVATION COMMISSION RECOMMENDATION:
(only required for signs or awnings in historic districts)

The Historic Preservation Commission recommends ____ Approval ____ Denial

Signature: _____ Date: _____



Customer: Smiles by Rosie

Policy Change:
Effective Immediately

Due to the large amount of proof revision requests, the first two layout proofs will be included as part of the project process. All further proof revisions will carry a $20 per revision charge.

Thank you for your understanding.

***

This proof is for conceptual use - actual sizes / colors / proportions may slightly vary.

SIGN★A★RAMA

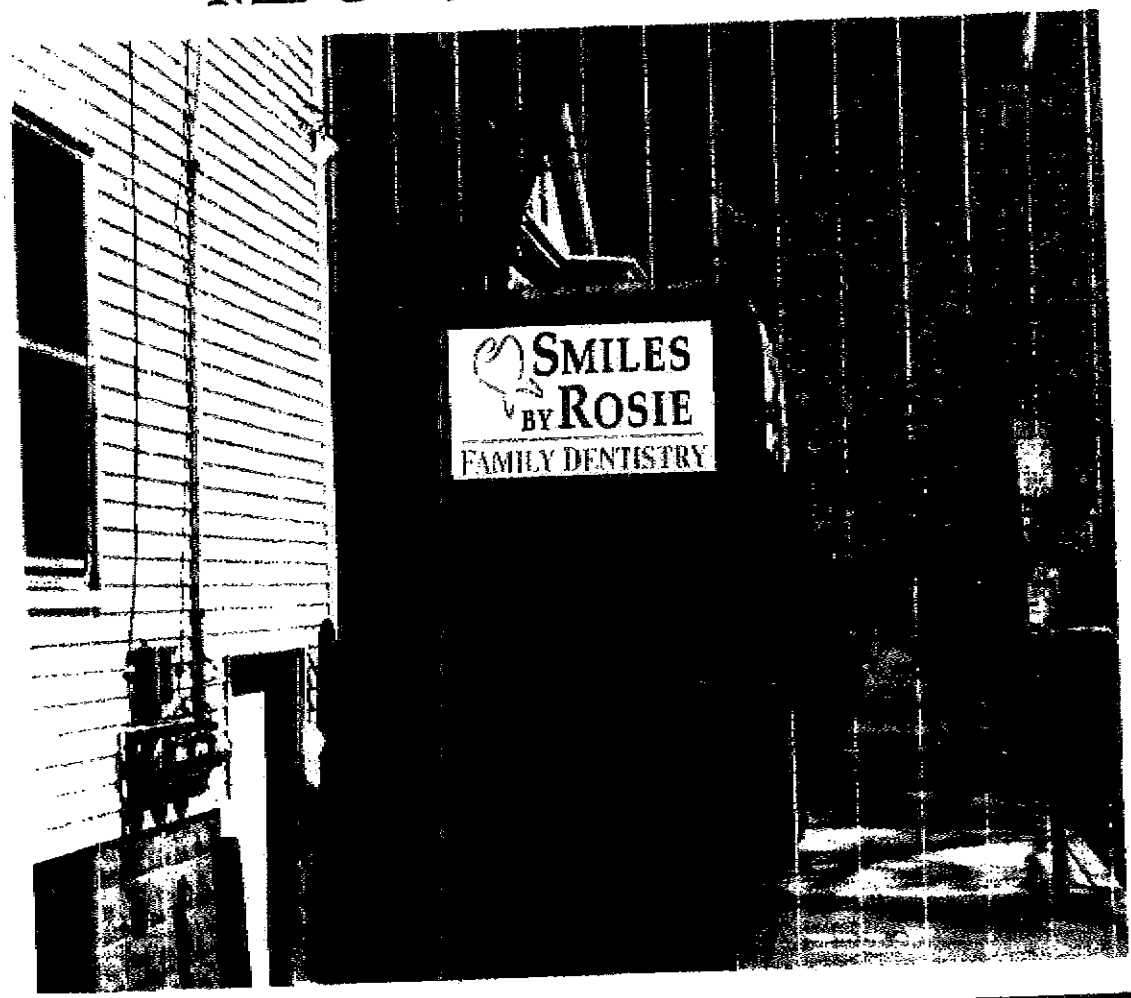
458 High Plain Street Tel: 508-660-1 231
Walpole, MA 02081 Fax 508-660-2754

Email: signaramanorwood@comcast.net

- Proof colors may vary from monitors & actual sign materials.
- A pdf proof is not a correct representation of printer output color.
- Resolution & Color from files provided by customer are the customers responsibility.
- Hard Proofs can be printed to ensure color satisfaction at a cost to be determined.

DATE: _____ APPROVED BY: _____

MDO - 40 in x 72 in



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DATE: _____ APPROVED BY: _____

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/27/2012

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	CONTACT NAME: Maureen Stephany
Integrated Insurance Solutions, LLC 1881 Worcester Road Suite 101 Framingham MA 01701	PHONE (A/C, No, Ext): (508) 370-0002 FAX (A/C, No): (508) 370-0758 E-MAIL ADDRESS: mstephany@iisagency.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Hanover Insurance Group	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Smiles By Rosie, Inc.
6 Kensington Avenue
Somerville MA 02145

COVERAGES **CERTIFICATE NUMBER:** CL127212708 **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 [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC			TBD	7/6/2012	7/6/2013	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [N] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		TBD	7/6/2012	7/6/2013	[X] WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 100,000 $ 100,000 $ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Certificate holder named as Additional Insured.

CERTIFICATE HOLDER

(617) 625-4239 jlong@somervillema.gov

John J. Long, City Clerk
City of Somerville
93 Highland Avenue
Somerville, MA 02143

CANCELLATION

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

Maureen Stephany/MSS

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.

F R [illegible]

*Signature of Individual or Corporate Name (Mandatory)

Katie-Rose Wagner

By: Corporate Officer (Mandatory, if a corporation)

45-4650934 TID

**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: Smiles By Rosie, Inc.

Address of taxpayer/applicant's business in Somerville: 6 Kensington Ave 02145

Address of taxpayer/applicant's home in Somerville: 20 Grove st #14 02144

Taxpayer/applicant's phone: day: (413) 329-8756 evening: _____

I, (print name) Katie-Rose Wagner, 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 11th day of May, 20 12. _____
(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: ___
# 8284	# 104/108001	#	#

NOTES:

CLERK'S INITIALS: CRS **ORIGINAL STAMP:**

SOMERVILLE CITY HALL • 93 HIGHLAND AVENUE • SOMERVILLE MASSACHUSETTS 02143
(617) 625-6600 EXT. 3500 • TTY: (866) 808-4851 • FAX: (617) 666-9682
WWW.SOMERVILLEMA.GOV

RECEIVED
5-29-12

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: SMILES BY ROSIE

Address:

City: State: Zip: Phone #:

☐ 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:

Address: SEE ATTACHED

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: _____ Date: _____

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)

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INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Hanover Insurance Group	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

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A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			TBD	7/6/2012	7/6/2013	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		TBD	7/6/2012	7/6/2013	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 100,000 $ 100,000 $ 500,000

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