



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

21521  
625

APR 07 2015

## Application to Renew Extended Operating Hours License

**Hess Retail Operations LLC**  
**1 HESS PLAZA**  
**WOODBIDGE NJ 07095**

**License #:** BL15-000854  
**File #:** 15-411  
**Fee:** 625 550

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)
<b>Business/DBA Name:</b> Hess Retail Operations LLC <b>Business Location:</b> 709 MCGRATH HWY <b>Business Phone:</b> 617-628-3871	
<b>License Holder:</b> Hess Retail Operations LLC 1 HESS PLAZA WOODBIDGE NJ 07095	
<b>Mailing Address:</b> Hess Retail Operations LLC 1 HESS PLAZA WOODBIDGE NJ 07095	
<b>Business Type:</b> Corporation HESS RETAIL HOLDINGS LLC	
<b>FID:</b> 222462225	
<b>Emergency Contact:</b> Andrew Bernstein <b>Phone:</b> 732-390-7890	Ed Salazar 617-628-3871
<b>Extended hours for in-store service (specify days and hours):</b> SUN-SAT 24 HOURS <b>Extended hours for take-out service (specify days and hours):</b> <b>Extended hours for delivery service (specify days and hours):</b>	

**Description of Location and/or Other Conditions:** The Licenseholder Must Regularly Clean the Property.

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: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Hess Retail Operations, LLC  
1 Hess Plaza / J Flaherty  
Woodbridge, NJ 07095  
732-750-6350  
732-352-6623 (fax)  
JFLAHERTY@SPEEDWAY.COM

CITY CLERK'S OFFICE  
SOMERVILLE, MA

2015 APR 22 PM 4:26



21521

City of Somerville, Massachusetts  
Finance Department, Treasury Division

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: Hess Retail Holdings LLC

Address of taxpayer/applicant's business in Somerville: 709 McGrath Hwy

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

Taxpayer/applicant's phone: day: 732-750-6350 evening: -

I, (print name) Danice Flaherty, 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 25 day of March, 2015. D Flaherty  
(Taxpayer's signature)

**CITY'S ACKNOWLEDGEMENT**

DATE OF ISSUANCE: 3-25-15 INCLUDES RELEVANT POSTINGS THROUGH: \_\_\_\_\_

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate ☐ Water/Sewer ☐ Personal Property ☐ Other: \_\_\_\_\_

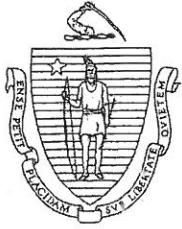
# 9881 # 144605001 # \_\_\_\_\_ # \_\_\_\_\_

NOTES:

CLERK'S INITIALS: JK

ORIGINAL STAMP:

3-25-15



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

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: Hess Retail Operations, LLC dba Hess Express 21521

Address: 709 McGrath Hwy

City/State/Zip: Somerville MA 02145 Phone #: 617-628-3871

Are you an employer? Check the appropriate box:

1. ☒ I am an employer with 5-10 employees (full and/or part-time).\*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity.  
[No workers' comp. insurance required]
3. ☐ 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]\*\*
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☒ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other

\*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: Old Republic Insurance Company

Insurer's Address: 445 S. Moorland Rd. Ste 300

City/State/Zip: Brookfield, WI 53005

Policy # or Self-ins. Lic. # MWC30246500 Expiration Date: 7/1/2015

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: 4/7/15

Phone #: 732-750-6350

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 #:



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

9/30/2014

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 Hylant Group - Cleveland 6000 Freedom Sq Dr, Ste 400 Independence OH 44131	CONTACT NAME: <u>Melissa Love</u>	FAX (A/C, No): <u>216-447-4088</u>	
	PHONE (A/C, No, Ext): <u>216-447-1050</u>	E-MAIL ADDRESS:	
INSURED MARAT-3 Hess Retail Operations, LLC 1 Hess Plaza Woodbridge, NJ 07095	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: <u>Old Republic Insurance Co</u>		<u>24147</u>
	INSURER B:		
	INSURER C:		
	INSURER D:		
	INSURER E:		
INSURER F:			

## COVERAGES

CERTIFICATE NUMBER: 839865088

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
	GENERAL LIABILITY					EACH OCCURRENCE \$
	<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY					DAMAGE TO RENTED PREMISES (Ea occurrence) \$
	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR					MED EXP (Any one person) \$
						PERSONAL & ADV INJURY \$
						GENERAL AGGREGATE \$
						PRODUCTS - COMP/OP AGG \$
	GEN'L AGGREGATE LIMIT APPLIES PER:					\$
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					COMBINED SINGLE LIMIT (Ea accident) \$
	AUTOMOBILE LIABILITY					BODILY INJURY (Per person) \$
	<input type="checkbox"/> ANY AUTO					BODILY INJURY (Per accident) \$
	<input type="checkbox"/> ALL OWNED AUTOS	<input type="checkbox"/> SCHEDULED AUTOS				PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS	<input type="checkbox"/> NON-OWNED AUTOS				\$
	UMBRELLA LIAB	<input type="checkbox"/> OCCUR				EACH OCCURRENCE \$
	EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$
	DED <input type="checkbox"/> RETENTION \$					\$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY		MVC30246500	10/1/2014	7/1/2015	WVC STATUTORY LIMITS OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y <input type="checkbox"/> N				E.L. EACH ACCIDENT \$5,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below	N/A				E.L. DISEASE - EA EMPLOYEE \$5,000,000
						E.L. DISEASE - POLICY LIMIT \$5,000,000

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

## CERTIFICATE HOLDER

## 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

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