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

2015 APR 30 P 12:47

CITY CLERK'S OFFICE
SOMERVILLE, MASS.

Application to Renew Flammables License

S GILL LLC
620 BROADWAY
SOMERVILLE MA 02145

License #: BLI5-000938
File #: 15-746
Fee: 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)
Business/DBA Name: S GILL LLC **Business Location:** 620 BROADWAY **Business Phone:** 617-628-9400	
License Holder: S GILL LLC 620 BROADWAY SOMERVILLE MA 02145	
Mailing Address: S GILL LLC 620 BROADWAY SOMERVILLE MA 02145	
Business Type: Corporation SUKHJINDER GILL SUKHJINDER GILL SUKHJINDER GILL	
FID: 999999999	
Emergency Contact: SUKHJINDER GILL **Phone:** 617-592-2001	
# of Gallons of Flammables to be Stored: 38055 **Describe Flammables to be Stored:** Not yet provided. **Proposed Hours of Operation:** Not yet provided.	

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: 4/30/15

Printed Name: Sukhjinder Gill Phone: 617-592-2001

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Somerville Citgo Inc

Address of taxpayer/applicant's business in Somerville: 620 Broadway

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

Taxpayer/applicant's phone: day: 781 521 3120 evening: 617 451 6885

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 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 4/28 day of 4/28, 20 15. _____
(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: ___

2239 # 30205001 # 209

NOTES:

CLERK'S INITIALS: LRC **ORIGINAL STAMP:** RECEIVED LBarnes 4-29-15

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

Workers' Compensation Insurance Affidavit - General Businesses

Applicant information:

Name: S. Gill LLC

Address: 620 B Broadway

City: Saulie State: Zip: MA Phone #: 02145

☐ 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: Public Mutual Ins

Address: One Park Ave N

City: New York State: NY Zip: 10016 Phone #:

Policy #: WC-041578-14 Expiration Date: 6/14/15

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: [signature] Date: 4/30/15

Print Name: Sukhsinder Gill

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

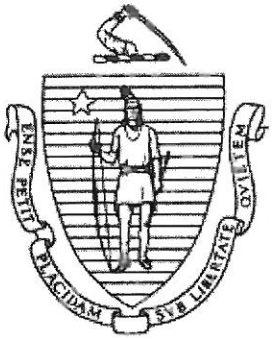
City or Town: _____ *Permit/License #:* _____

☐ *Board of Health*
☐ *Building Department*
☐ *City/Town Clerk*
☐ *Licensing Board*
☐ *Selectmen's Office*
☐ *Other* _____

Contact Person: _____ *Phone #:* _____

(revised Jan. 2008)

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111

617-727-4900 - http://www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

PUBLIC SERVICE INSURANCE COMPANY

NAME OF INSURANCE COMPANY

One Park Ave New York, NY 10016

ADDRESS OF INSURANCE COMPANY

WC-041578-14 06/14/2014 06/14/2015

POLICY NUMBER EFFECTIVE DATES

PRESCOTT & SON INSURANCE AGENCY. INC.
963 EASTERN AVENUE MALDEN MA 02148 (781) 322-2350

NAME OF INSURANCE AGENT ADDRESS PHONE #

Gil LLC dba Shield Service Station

EMPLOYER ADDRESS

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER