CITY OF SOMERVILLE
BOARD OF ALDERMEN
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143
(617) 625-6600

APPLICATION TO RENEW OUTDOOR SEATING LICENSE

License #: **1016**

LDDJ, INC.
DAVE'S FRESH PASTA
79-87 HOLLAND STREET
SOMERVILLE, MA 02144

Fee: **.00**
Account ID: **451**
Reference #: **1016**

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: **DAVE'S FRESH PASTA** Business Location: **79 HOLLAND ST** Business Phone: **(617)623-0867**	
License Holder: **LDDJ, INC.** **DAVE'S FRESH PASTA** **79-87 HOLLAND STREET** **SOMERVILLE, MA 02144** **(617)623-0867**	
Mailing Address: **LDDJ, INC.** **DAVE'S FRESH PASTA** **79-87 HOLLAND STREET** **SOMERVILLE, MA 02144**	
Business Type: **CORPORATION (INC. LLC)** **PRESIDENT - DAVID JICK** **TREASURER - DAVID JICK** **SECRETARY - LORI DELISO**	
FID: **043255141**	
Food Manager/Emergency Contact: **DAVID JICK** **617-938-1000**	

Conditions: *(to change any conditions, submit a new application. Contact the City Clerk's Office for more information)*

Hours: **MO-SU 5-10PM SEATS/9PM GOODS**

12 SEATS
1 A-FRAME SIGNS
6 TABLES

Description of Location and/or Other Conditions:

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 _____

Print Name: _____ Phone _____

Client#: 303789 DAVESFRESH

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/30/2014

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 HUB Int'l New England (ABIA) 299 Ballardvale Street Wilmington, MA 01887 978 657-5100	CONTACT NAME: Alice Croke PHONE (A/C, No, Ext): 978 657-5100 FAX (A/C, No): 978-988-0038 E-MAIL ADDRESS:
INSURED Dave's Fresh Pasta DBA LDDJ Inc. 81 Holland Street Somerville, MA 02144	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Selective Insurance Company of INSURER B : Mass Retail Merchants WC INSURER C : Western Surety Company INSURER D : INSURER E : INSURER F :

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			S1889563	06/16/2014	06/16/2015	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$3,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$3,000,000
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
a	X UMBRELLA LIAB X OCCUR			S1889563	06/16/2014	06/16/2015	EACH OCCURRENCE	$1,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$1,000,000
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			TO FOLLOW	FROM	CARRIER	WC STATU-TORY LIMITS OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	N / A					E.L. EACH ACCIDENT	$
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
C	Surety Bonds Sign Installation			69928083	07/08/2014	07/08/2015	2,000	

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

City of Somerville as additional insured.

CERTIFICATE HOLDER

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

CITY OF SOMERVILLE, MASSACHUSETTS
Treasury Department
JOSEPH A. CURTATONE
MAYOR

CERTIFICATE OF GOOD STANDING

PLEASE PRINT

NAME OF PERSON REQUESTING CERTIFICATE:

BUSINESS LOCATION: 81 Holland st AND/OR

TAXPAYER'S HOME ADDRESS:

TAXPAYER/APPLICANT PHONE: DAY: 617 623 0867 EVENING: 781 863 6375

BUSINESS NAME: CDDS inc Dave's Fresh Pasta

BUSINESS ID NUMBER: ~~617623087~~ 043255141 BUSINESS PHONE: 617 623 0867

I (print name) Dave Tick, the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and all taxes and fees due to the City of Somerville 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 29 day of OCTOBER 2014. _____ (Taxpayer's Signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: 10-29-14

TAXES AND ACCOUNT NUMBER(S)

**REAL ESTATE ID	**WATER/SEWER ID	**PERSONAL PROPERTY	**OTHER
	326010001	628	

NOTES:

CLERKS INITIALS: SK

BUSINESS or BUILDING PERMIT

ORIGINAL STAMP

RECEIVED 10-29-14

Somerville City Hall • 93 Highland Avenue • Somerville, Massachusetts 02143
(617) 625-6600, Ext. 3500 • TTY: (617) 666-0001 • Fax: (617) 666-9682
www.somervillema.gov

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: _____

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: SEE ATTACHED.

Address: _____

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)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE CERTIFICATE

INFORMATION PAGE

RENEWAL AGREEMENT

MA Retail Merchants WC Group Inc.
PO Box 859222-9222
Braintree, MA 01285
(Carrier Code: 34355)

Producer: Agent# 5960
Association Benefits Insurance Age
299 Ballardvale St, Suite 1
Wilmington, MA 01887
Certificate #: 014005030519114
Prior Certificate #: 014005030519113

1. The Employer: Dave's Fresh Pasta
LDDJ Inc
Mailing Address: 81 Holland Street
Somerville, MA 02144

Fein: 043255141
Type of Business: Corporation
Risk ID:

Other workplaces not shown above:
NO OTHER WORKPLACES FOR THIS POLICY

2. The certificate period is from 12:01 a.m. on 1/01/2014 to 12:01 a.m. on 1/01/2015 at the insured's mailing address.

3. A. Workers Compensation Coverage: Part One of the certificate applies to the Workers Compensation Law of the states listed here:
MA

B. Employers Liability Coverage: Part Two of the certificate applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$ 100,000	each accident
Bodily Injury by Disease	$ 500,000	certificate limit
Bodily Injury by Disease	$ 100,000	each employee

C. Other States Coverage:

D. This certificate includes these endorsements and schedules:
WC000000A(04/92) WC000310(04/84) WC000406A(08/95) WC000414(07/90) WC000422A(09/08)
WC200301(04/84) WC200302(05/86) WC200303B(07/99) WC200405(06/01) WC200601(06/92)

4. The contribution for this certificate will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications	Code No.	Contribution Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Contribution
SEE SCHEDULE OF OPERATIONS				

Total Estimated Annual Contribution 11,057.00

Minimum Contribution $ 293.00 Expense Constant $ .00

WC 00 00 01 A Issue Date: 1/27/2014 Countersigned by _____