



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

12-13-12
CK 12420
\$ 550-

APPLICATION TO RENEW USED CAR DEALER CLASS 2 LICENSE

LEINS AUTO REPAIR INC.
65 BOW ST
SOMERVILLE, MA 02143

License #: 997

Fee: 550.00

Account ID: 479

Reference #: 997

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: For LEINS AUTO REPAIR Business Location: 69 BOW ST Business Phone: 617-623-9000	
License Holder: LEINS AUTO REPAIR INC. 65 BOW ST SOMERVILLE, MA 02143 617-623-9000	
Mailing Address: LEINS AUTO REPAIR INC. SOMERVILLE, MA 02143	
Business Type: CORPORATION (INC. LLC) PRESIDENT - LUIS LEINS SECRETARY - LUIS LEINS	
FID: 542080683	
Food Manager/Emergency Contact: LUIS LEINS	

2012 DEC 13 P 12:53
CITY CLERK'S OFFICE
SOMERVILLE, MA

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

Hours: **MO-FR 8AM-6PM, SA 8AM-2PM**

17 VEHICLES

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 _____

IMPORTANT

It's time to renew your Used Car Dealer's license. We are converting to new software, and the enclosed page shows the information we have on file for your license. Please fill out that page AND the 6 boxes below with the correct information. Return all 4 pages with your fee AND with evidence that your Used Car Dealer's Bond is up to date. Call John Long, City Clerk, at 617 625-6600 x4110 if you have any questions.

The DBA Name of the Business: Leins Auto Repair Inc.
Somerville Address and Zip Code: 65 1/2 Bow St 02143
Phone Number of the Business: 617-623-9000

The Legal Name of the License Holder: Leins Auto Repair Inc.
Street Address of the License Holder: 65 1/2 Bow St
City, State and Zip Code of the License Holder: Somerville, MA 02143
Phone Number of the License Holder: 617-623-9000

Where We Should Send Mail: Name: _____
Street Address: 65 1/2 Bow St.
City, State and Zip Code: Somerville MA 02143

Federal ID # (Do Not Give a Social Security #): 54-2080683

Emergency Contact and his/her Phone Number: 617

Type of Business (Check Only One and Print the Names Indicated):
☐ Sole Proprietor: Name of Owner: _____
☐ Partnership (inc. LLP): Name of Partnership: _____
Names of All Partners Who Own More Than 10%: _____
☐ Trust: Name of Trust: _____
Names of All Trustees Who Own More Than 10%: _____
☒ Corporation: Name of Corporation: Leins Auto Repair Inc.
Name of President: Luis Leins
Name of Secretary: Luis Leins Name of Treasurer: Luis Leins
☐ LLC: Name of LLC: _____
Names of All Managers: _____
Other (Attach a Description of the Form of Ownership and the Names of the 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 Licensing Commission.
-I have filed all State tax returns and paid all State taxes required by law for this business.

License Holder Signature: _____ Date 12-13-12

CNA SURETY

CNA Plaza, Chicago IL 60685-0001

Jennifer B. Schaller
Counsel
Telephone 312-822-7049
Facsimile 312-755-3737

Re: Second Hand Motor Vehicle Dealer Bond Certificate of
Continuance for Western Surety Bonds

Western Surety is an underwriting company of CNA Surety and we are contacting your office because several of our bond principals received correspondence indicating the need for a Certificate of Continuance for their Second Hand Motor Vehicle Dealer Bonds issued by Western Surety.

Western Surety's standard bond form expressly states: "This bond shall be continuous and may be cancelled by the Surety by giving (30) days' written notice of cancellation to the municipal licensing authority at (address) by First Class Mail." (emphasis added)." Since, Western Surety's bond form is continuous, it would be inappropriate for Western Surety to issue a Continuation Certificate.

The Commonwealth of Massachusetts, Registry of Motor Vehicles has reviewed Western Surety's bond form and has clearly stated that municipalities do not need to require additional evidence that the bond is in effect. (See attached letter from Attorney William McVey dated November 19, 2004).

If you have any questions, or we can be of any further assistance, please feel free to contact me at (312) 822-7049.

Sincerely,

Jennifer B. Schaller

Jennifer B. Schaller



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Leins Auto Repair Inc.

Address of taxpayer/applicant's business in Somerville: 69-71 Bow St.

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

Taxpayer/applicant's phone: day: 617-623-9000 evening: _____

I, (print name) Luis E. Leins, 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 13 day of December, 2012.

(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: _____

16537083 # 232058001 # 30052446 # _____

NOTES:

CLERK'S INITIALS: M. M.

ORIGINAL STAMP:



RECEIVED
12-13-12

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: Leins Auto Repair Inc.
Address: 65 1/2 Bow St.
City: Somerville State: MA Zip: 02131 Phone #: 617-623-9000

- | | | |
|--|-----------------------|---|
| <input type="checkbox"/> I am an employer with <u>2</u> employees (full and/or part time). | Business Type: | <input type="checkbox"/> Retail |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees. | | <input type="checkbox"/> Restaurant/Bar/Eating Establishment |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. | | <input checked="" type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees. | | <input type="checkbox"/> Nonprofit |
| | | <input type="checkbox"/> Entertainment |
| | | <input type="checkbox"/> Manufacturing |
| | | <input type="checkbox"/> Health Care |
| | | <input type="checkbox"/> Other _____ |

Workers' compensation insurance information (if applicable):

Insurance Company Name: Utica National Insurance Group.
Address: 180 Genesee St.
City: New Hartford State: NY Zip: 13413 Phone #: _____
Policy #: 4265993 Expiration Date: 11-25-2013

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: 12-13-12

Print Name: _____

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

City or Town: _____	Permit/License #: _____	<input type="checkbox"/> Board of Health
		<input type="checkbox"/> Building Department
		<input type="checkbox"/> City/Town Clerk
		<input type="checkbox"/> Licensing Board
		<input type="checkbox"/> Selectmen's Office
Contact Person: _____	Phone #: _____	<input type="checkbox"/> Other _____

**UTICA NATIONAL INSURANCE GROUP**180 Genesee Street
New Hartford, NY 13413

WC 000001A

Issuing Company: Utica Mutual Insurance Company
MEMBER OF UTICA NATIONAL INSURANCE GROUP**WORKERS COMPENSATION AND
EMPLOYERS LIABILITY INSURANCE POLICY****Information Page****1. The Insured and Mailing Address:**LEINS AUTO REPAIR, INC.
65 1/2 BOW STREET

SOMERVILLE

MA 02143

Policy Number: 4265993**Renewal****Prior Policy Number:****Producer:** Prescott & Son Ins Agcy
963 Eastern Avenue
Malden, MA 02148**Producer Number:** 70164**SIC#:** 55211**Entity of Insured:** Corporation**Other workplaces not shown above:****Insured's I.D. Number:** 542080683**Risk I.D. Number:** MA: 000173165**NCCI Company Number:** 15717**2. The policy period is from** 11/25/2012 **to** 11/25/2013 **12:01 AM Standard Time at the insured's mailing address.****3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:** Massachusetts**B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A.**
The limits of our liability under Part Two are:

Bodily Injury by Accident	\$ \$500,000	Each Accident
Bodily Injury by Disease	\$ \$500,000	Policy Limit
Bodily Injury by Disease	\$ \$500,000	Each Employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

All States except those listed in Item 3.A., ND, OH, WA, WY

D. This policy includes these endorsements and schedules:**4. The premium for this policy 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.

<input checked="" type="checkbox"/> See Extension of Information Page Classifications	Code No.	Premium Basis Total est. Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
Minimum Premium: \$ 265 Employer's Liab Minimum Premium: \$ If indicated below, interim adjustments of premium shall be made:	MA	Expense Constant Total Estimated Annual Premium Deposit Premium	\$ \$ \$	 1,801 1,801

100813251

Issuing Office:

8-D-WC Ed. 08-2008

Date of Issue:**Countersigned by**

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