

TOPA INSURANCE COMPANY

LIQUOR LIABILITY APPLICATION

(Please complete a separate application for each location)

Applicant & Mailing Address							Date	
Location Address						Producer		
Individual <input type="checkbox"/>	Partnership <input type="checkbox"/>	Corporation <input type="checkbox"/>	Joint Venture <input type="checkbox"/>	Other <input type="checkbox"/>	Name on liquor license and number			
Type of operation: Bar/Tavern <input type="checkbox"/> Club <input type="checkbox"/> Restaurant <input type="checkbox"/> Store <input type="checkbox"/> Other (Explain)								
Type of liquor sold Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/>				Population of Area			Area Industrial/commercial <input type="checkbox"/> Residential <input type="checkbox"/> Rural <input type="checkbox"/>	
Clientele: Residents/Workers <input type="checkbox"/> Tourist <input type="checkbox"/> Other (Explain)								
Experience under present ownership? Yr. Mo.				If less than three years, explain prior experience				
Has applicant's liquor license ever been suspended? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain.								
Is there any? Dancing? Yes <input type="checkbox"/> No <input type="checkbox"/> Nude dancing or waitress? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Describe entertainment or activities other than consumption of alcohol that occur?								
Explain any special promotion? Happy Hour? Yes <input type="checkbox"/> No <input type="checkbox"/> Ladies Night? Yes <input type="checkbox"/> No <input type="checkbox"/> Similar promotions? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain item checked Yes:								
Bouncers Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of: Waitress(s) _____ Bouncers _____ Bartender(s) _____ Other _____			Formal safety program conducted/employee training Yes <input type="checkbox"/> No <input type="checkbox"/>			
Explain fully procedure for handling intoxicated patrons:								
Any claims made within the last five (5) years? Yes <input type="checkbox"/> No <input type="checkbox"/>				If yes, explain:				
Prior Carrier				Limits \$			Premium: \$	
Current General Liability Carrier:				Limits \$			Premium: \$	
Gross Sales? Liquor: \$ Food: \$ Other: \$								
From		Policy Term To		Limit of liability: \$		Aggregate		
Additional Insureds: Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, name and address?						
Person to contact for Inspection:						Phone:		
Applicant Signature				Date		Producer Name & Signature		Date