

# Restaurant / Tavern Application

All questions must be answered in full. Application must be signed and dated by the applicant.

Applicant's Name \_\_\_\_\_ Agent \_\_\_\_\_

Applicant Mailing Address \_\_\_\_\_ Applicant's Phone Number \_\_\_\_\_

\_\_\_\_\_ Web Address \_\_\_\_\_

\_\_\_\_\_ Inspection Contact \_\_\_\_\_

Proposed Policy Period \_\_\_\_\_ to \_\_\_\_\_ Phone Number for Inspection Contact \_\_\_\_\_

Applicant is  Individual  Partnership  Corporation  Joint Venture  Other \_\_\_\_\_

Location #1 \_\_\_\_\_

Location #2 \_\_\_\_\_

Location #3 \_\_\_\_\_

## GENERAL INFORMATION

1. Number of years in business? \_\_\_\_\_ At this location? \_\_\_\_\_

If new, describe prior experience: \_\_\_\_\_

2. Gross Sales: Total \$ \_\_\_\_\_ Catering \_\_\_\_\_

Food \$ \_\_\_\_\_ Delivery (fast food) \_\_\_\_\_

Liquor \$ \_\_\_\_\_ Street Fairs \_\_\_\_\_

3. Total Number of Employees Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Servers Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Bartenders Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

4. Operating hours \_\_\_\_\_ Days \_\_\_\_\_

5. Premises:  Owned  Leased Total Square Footage occupied by applicant \_\_\_\_\_ Seating Capacity \_\_\_\_\_

## COOKING CONTROLS

1. Ansul System? .....  Yes  No

2. Number of Cooking Facilities? ..... Ranges \_\_\_\_\_ Ovens \_\_\_\_\_ Deep Fat Fryers \_\_\_\_\_ Broilers \_\_\_\_\_ Grills \_\_\_\_\_

3. Service Agreement in place? .....  Yes  No

4. Cooking performed under hoods? .....  Yes  No

Service Agreement in place for cleaning ducts? .....  Yes  No

Describe Service Schedule. \_\_\_\_\_



**ADJACENT EXPOSURES**

	RIGHT	LEFT	FRONT	REAR
Loc. 1				
Loc. 2				
Loc. 3				

**CONTRIBUTING INSURANCE**

NAME & ADDRESS OF COMPANY	% PARTICIPATION	LIMITS
_____		
_____		
_____		

**LIMITS – GENERAL LIABILITY (PER OCCURRENCE)**

- GENERAL AGGREGATE (OTHER THAN PRODUCTS/COMPLETED OPERATIONS) \$ \_\_\_\_\_
- PRODUCTS & COMPLETED OPERATIONS AGGREGATE \$ \_\_\_\_\_
- PERSONAL & ADVERTISING INJURY (ANY ONE PERSON OR ORGANIZATION) \$ \_\_\_\_\_
- EACH OCCURRENCE \$ \_\_\_\_\_
- DAMAGE TO PREMISES RENTED TO YOU (ANY ONE PREMISES) \$ \_\_\_\_\_
- MEDICAL EXPENSE (ANY ONE PERSON) \$ \_\_\_\_\_

**CERTIFICATE RECIPIENTS / ADDITIONAL INTERESTS**

NAME AND ADDRESS	RELATIONSHIP TO APPLICANT	ADDITIONAL INSURED	CERTIFICATE
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>

**PRIOR CARRIER HISTORY & LOSS INFORMATION**

**PRIOR CARRIERS (LAST THREE YEARS):**

YEAR	CARRIER	POLICY NUMBER	LIMITS	PREMIUM

