



City of South St. Paul Business License Application

City Clerk's Office
125 3rd Avenue North
South St. Paul, MN 55075
(651)554-3205
Fax: (651)554-3201

TYPE OF LICENSE(S) APPLYING FOR:

License Year: _____

(X)	LICENSE	FEE	FEE INFORMATION	INSURANCE REQUIREMENTS
	BARBER	10.00	PER CHAIR	
	BEAUTY SHOP	10.00	PER CHAIR	
	BEER 3.2 ON SALE	150.00		Certificate of Insurance
	BEER 3.2 OFF SALE	50.00		Certificate of Insurance
	BEER 3.2 ON SALE TEMPORARY (See page 2)	50.00		Certificate of Insurance
	BENCHES-LIMIT 25	20.00	PER BENCH	Certificate of Insurance
	BOWLING ALLEY	50.00	FIRST LANE-\$10.00 EACH ADD'L	
	CAR WASH	75.00		Certificate of Insurance
	CIGARETTE	100.00		
	ENTERTAINMENT	100.00		
	FUEL DEALER	10.00		
	HOTEL	50.00	PLUS \$5.00 PER ROOM	
	HOUSE MOVING	25.00	PER YEAR, \$500.00 PER HOUSE	
	MECHANICAL AMUSEMENT DEVICES (See page 2)	15.00	PER LOCATION + \$15.00 PER MACHINE	
	MECHANICAL MUSIC (See page 2)	15.00	PER LOCATION + \$15.00 PER MACHINE	
	MASSAGE THERAPY	50.00	+ \$10.00 INVEST. FEE	Certificate of Insurance
	PAWNBROKERS	3,000.00	+ \$500.00 INVEST. FEE (IN MN) + \$1500.00 INVEST. FEE (OUT OF STATE)	\$3,000 License Bond
	PEDDLERS, SOLICITORS & CANVASSERS	50.00	+ \$10.00 INVESTIGATION FEE	\$1,000 License Bond
	PETROLEUM	50.00	+ \$5.00 PER PUMP	
	POOL TABLE	15.00	PER LOCATION + \$15.00 PER MACHINE	
	RETAIL FOOD SALES	50.00	EACH LOCATION OR VEHICLE	
	RESTAURANT	100.00		
	SPECIAL EVENT (See page 2)	25.00	PER DAY	
	SOFT DRINKS, GUM, CANDY & NUTS	15.00	PER LOCATION	
	TATTOO AND BODY PIERCING	150.00	+ \$50.00 APPLICATION FEE AND + \$150.00 INVESTIGATION FEE	License Bond
	TAXI CABS	100.00	PER COMPANY + \$25.00 EACH VEHICLE	Certificate of Insurance
	THEATER	100.00		
	TRASH HAULER - RESIDENTIAL or COMMERCIAL	200.00	+ \$5.00 PER TAB	Certificate of Insurance
	TRASH HAULER - RESIDENTIAL & COMMERCIAL	400.00	+ \$5.00 PER TAB	Certificate of Insurance
	USED CLOTHING SALES	50.00		

Business Name:		Business Phone:	
Address:		City, State, Zip	
Please Check: _____ Corporation _____ Partnership _____ Individual _____ Other			
Owner of Business or Individual Applying for License:		Phone:	
Address:		City, State, Zip	
Social Security #: (Required by MN Statutes 270C.72)		Drivers License #:	State of Issuance:
Minnesota Business Tax ID#:		Federal Business Tax ID#	

CITY OF SOUTH ST. PAUL
TAXI DRIVER LICENSE APPLICATION

PLEASE PRINT:

Applicant Name: _____
Last First Middle

Address: _____
Street Address City State Zip

Home Phone: _____
(Include Area Code)

Place of Birth: _____ Date of Birth (MM/DD/YY): _____

U.S. Citizen: _____ Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
 Yes No

Do you wear corrective lenses?
 Yes No

Business Name: _____ Phone: _____
(Include Area Code)

Address: _____
Street Address City State Zip

Minnesota Business Tax ID Number _____ Applicant's Social Security Number: _____
(if applicable):

Federal Business Tax ID Number: _____

Have you previously been denied a taxicab driver's license or had such license revoked and, if so, when, where and for what reason?

Do you have a valid driver's license? _____ Driver's License Number: _____ State: _____
 Yes No

If no, ID Card Number: _____ State: _____

Has your driver's license ever been suspended or revoked? YES NO (If yes, explain below)

Have you ever been convicted of any crime other than a traffic-related offense? YES NO (If yes, explain below)

CITY OF SOUTH ST. PAUL
DRIVER INFORMATION

A separate Driver Information application must be completed for each driver who will operate the taxicabs listed on the license application.

TAXICAB DRIVER: _____
Full Name (Last, First, Middle)

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

HEALTH HISTORY

DATE OF BIRTH _____ AGE ____ HEIGHT _____ WEIGHT _____

HAVE YOU BEEN TREATED WITHIN THE LAST YEAR FOR ANY OF THE FOLLOWING?

1. EYE PROBLEMS: YES ____ NO ____ IF YES, EXPLAIN: _____

Is your eyesight at least 20/40 (Corrected/Uncorrected) YES ____ NO ____

2. HEART PROBLEMS: YES ____ NO ____ IF YES, EXPLAIN: _____

3. MENTAL OR NERVOUS PROBLEMS: YES ____ NO ____ IF YES, EXPLAIN: _____

4. ALCOHOL ABUSE: YES ____ NO ____ IF YES, EXPLAIN: _____

5. DRUG ABUSE: YES ____ NO ____ IF YES, EXPLAIN: _____

6. EPILEPSY, SEIZURES: YES ____ NO ____ IF YES, EXPLAIN: _____

7. ARE YOU CURRENTLY TAKING PRESCRIBED MEDICATION? YES ____ NO ____

IF YES, WHAT KIND AND FOR WHAT REASON? _____

8. I CERTIFY THAT I HAVE GOOD EYESIGHT AND AM NOT NOW SUBJECT TO ANY DISEASE OR INFIRMITY OF BODY OR MIND WHICH MIGHT RENDER ME UNFIT TO OPERATE A TAXI CAB.

DRIVER HISTORY

DO YOU HAVE A VALID STATE OF MINNESOTA DRIVER'S LICENSE? YES NO

DO YOU HAVE A CURRENT, VALID TAXICAB LICENSE WITH THE CITY OF ST. PAUL? (PLEASE ATTACH COPY.) YES NO

DRIVER'S LICENSE NO.: _____

HAS THE DRIVER BEEN CONVICTED OF ANY OF THE FOLLOWING VIOLATIONS OF MINNESOTA STATUTES?

- | | | |
|---|-----|----|
| • Murder, Criminal vehicular homicide, and injury? | YES | NO |
| • Assault in the first, second, or third degree? | YES | NO |
| • Criminal sexual conduct? | YES | NO |
| • Felony or gross misdemeanor indecent exposure? | YES | NO |
| • Controlled substances punishable by a maximum sentence of 15 years or more? | YES | NO |

CITY OF SOUTH ST. PAUL
DRIVER INFORMATION

• Driving under the influence, leaving the scene of an accident,
or reckless or careless driving? YES NO

Has the driver been adjudged legally incompetent by reason of
mental illness, mental deficiency, or inebriety? YES NO

Has the driver been convicted of a crime of violence or theft,
a sex crime, or a crime involving the illegal use of drugs? YES NO

Has the driver had driving violations within five years prior to
the license application? YES NO

A CRIMINAL HISTORY RECORD MUST BE SUBMITTED FOR EACH DRIVER INFORMATION APPLICATION

Criminal History Records can be obtained from the Minnesota Bureau of Criminal Apprehension, Criminal Justice Information Systems - CHA, 1430 Maryland Avenue East, St. Paul, MN 55106. Call the BCA at (651) 793-2400 from 8:00 a.m. to 4:30 p.m. if you need additional information. BCA lobby hours are 8:15 a.m. to 4:00 p.m., Monday through Friday, closed holidays. BCA website is www.dps.state.mn.us/bca.

Has the driver submitted a FULL criminal history record? YES NO

THE ABOVE ANSWERS ARE TRUE AND COMPLETE AND ARE GIVEN AS A CONDITION FOR OBTAINING A LICENSE TO OPERATE A TAXI CAB IN THE CITY OF SOUTH ST. PAUL. ANY FALSE OR INCOMPLETE STATEMENTS OR FAILURE TO REVEAL A MEDICAL CONDITION MAY BE REASON TO DENY OR REVOKE THE REQUESTED LICENSE.

Driver Signature

Date

FOR DEPARTMENT USE ONLY: APPROVED _____ DENIED _____

INVESTIGATOR'S NAME (PLEASE PRINT)

INVESTIGATOR'S SIGNATURE

FORM SP:C1
LICENSE APPLICANT:

PURSUANT TO MINNESOTA STATUTE 270.70 TAX CLEARANCE: ISSUANCE OF LICENSES
THE LICENSING AUTHORITY IS REQUIRED TO PROVIDE TO THE MINNESOTA COMMISSIONER OF
REVENUE YOUR MINNESOTA BUSINESS TAX IDENTIFICATION NUMBER AND THE SOCIAL SECURITY
NUMBER OF EACH LICENSE APPLICANT.

UNDER THE MINNESOTA DATA PRACTICES ACT AND THE FEDERAL PRIVACY ACT OF 1974, WE ARE
REQUIRED TO ADVISE YOU OF THE FOLLOWING REGARDING THE USE OF THIS INFORMATION:

1. THIS INFORMATION MAY BE USED TO DENY THE ISSUANCE, RENEWAL OR TRANSFER OF
YOUR LICENSE, IN THE EVENT YOU OWE THE MINNESOTA DEPARTMENT OF REVENUE
DELINQUENT TAXES, PENALTIES OR INTEREST;
2. UPON RECEIVING THIS INFORMATION, THE LICENSING AUTHORITY WILL SUPPLY IT ONLY
TO THE MINNESOTA DEPARTMENT OF REVENUE. HOWEVER, UNDER THE FEDERAL
EXCHANGE OF INFORMATION AGREEMENT, THE DEPARTMENT OF REVENUE MAY
SUPPLY THIS INFORMATION TO THE INTERNAL REVENUE SERVICE.
3. FAILURE TO SUPPLY THIS INFORMATION MAY JEOPARDIZE OR DELAY THE PROCESSING
OF YOUR LICENSE ISSUANCE OR RENEWAL APPLICATION.

PLEASE SUPPLY THE FOLLOWING INFORMATION AND RETURN ALONG WITH YOUR APPLICATION
TO THE AGENCY ISSUING THE LICENSE. **DO NOT RETURN TO THE DEPARTMENT OF REVENUE.**

LICENSE BEING APPLIED FOR OR RENEWED: _____

LICENSING AUTHORITY: _____
(Name of City, County or State Agency Issuing License)

PERSONAL INFORMATION

APPLICANT'S NAME: _____

APPLICANT'S ADDRESS: _____
City County State Zip Code

SOCIAL SECURITY NUMBER: _____

BUSINESS INFORMATION

BUSINESS NAME: _____

BUSINESS ADDRESS: _____
City County State Zip Code

MINNESOTA TAX IDENTIFICATION NO.: _____

FEDERAL TAX IDENTIFICATION NO.: _____

IF A MINNESOTA TAX IDENTIFICATION NUMBER IS NOT REQUIRED, PLEASE EXPLAIN ON THE
REVERSE SIDE.

Signature

Date

CITY OF SOUTH ST. PAUL

**AFFIDAVIT OF GOOD CHARACTER
IN SUPPORT OF LICENSE APPLICATION**

[Applicant(s) name, not business name]

AFFIDAVIT

"I am personally acquainted with, and am not a relative of, the above-referenced applicant for a City of South St. Paul license."

"I have known the applicant personally, have observed his/her conduct for the past five years, and vouch for his/her honesty and good character as a reputable citizen."

"I certify the foregoing statement is true to the best of my knowledge and belief."

Signature of Affiant

Date

Print Full Name of Affiant

Date of Birth of Affiant

Street Address

City

State

Zip

Home Telephone # (include area code)

(NOTE: Three (3) of these forms are required.)

CITY OF SOUTH ST. PAUL

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IN SUPPORT OF LICENSE APPLICATION**

[Applicant(s) name, not business name]

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"I certify the foregoing statement is true to the best of my knowledge and belief."

Signature of Affiant

Date

Print Full Name of Affiant

Date of Birth of Affiant

Street Address

City

State

Zip

Home Telephone # (include area code)

(NOTE: Three (3) of these forms are required.)

CITY OF SOUTH ST. PAUL

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"I certify the foregoing statement is true to the best of my knowledge and belief."

Signature of Affiant

Date

Print Full Name of Affiant

Date of Birth of Affiant

Street Address

City

State

Zip

Home Telephone # (include area code)

(NOTE: Three (3) of these forms are required.)

**APPLICATION FOR LICENSE INVOLVING
PRIVATE OR CONFIDENTIAL INFORMATION
(TENNESSEN WARNING)**

IN CONNECTION WITH YOUR REQUEST FOR A LICENSE, THE CITY HAS ASKED THAT YOU PROVIDE IT WITH INFORMATION ABOUT YOURSELF WHICH IS CLASSIFIED AS EITHER PRIVATE OR CONFIDENTIAL BY THE MINNESOTA GOVERNMENT DATA PRACTICES ACT (M.S.A. 13.04). ACCORDINGLY, THE CITY IS REQUIRED TO INFORM YOU OF THE FOLLOWING:

1. THE PURPOSE AND INTENDED USE OF THE INFORMATION REQUESTED IS: TO DETERMINE IF YOU ARE ELIGIBLE FOR A LICENSES FROM THE CITY OF SOUTH ST. PAUL.
2. YOU ARE NOT LEGALLY OBLIGATED TO SUPPLY THE REQUESTED INFORMATION.
3. THE KNOWN CONSEQUENCES OF SUPPLY THE REQUESTED INFORMATION IS: THE INFORMATION, OR FURTHER INVESTIGATION COULD DISCLOSE INFORMATION, WHICH COULD CAUSE YOUR APPLICATION TO BE DENIED.
4. THE KNOWN CONSEQUENCES OF REFUSING TO SUPPLY THE REQUESTED INFORMATION IS: YOUR REQUEST FOR A LICENSE CANNOT BE PROCESSED.
5. THE FOLLOWING PERSON AND ENTITIES ARE AUTHORIZED BY LAW TO RECEIVE THE INFORMATION IF PROVIDED: STAFF OF THE SOUTH ST. PAUL POLICE DEPARTMENT, BUREAU OF CRIMINAL APPREHENSION, DAKOTA COUNTY WARRANT OFFICE, STATE OF MINNESOTA - DRIVER LICENSE SECTION, DAKOTA COUNTY AUDITOR, OTHER GOVERNMENTAL AGENCIES NECESSARY TO PROCESS YOUR APPLICATION.

THE UNDERSIGNED, BY SIGNING THIS NOTICE, ACKNOWLEDGES THAT HE/SHE HAS READ AND UNDERSTOOD THE CONTENTS OF THIS NOTICE AND HAS RECEIVED A COPY OF THIS NOTICE.

NAME (PLEASE PRINT)

SIGNATURE

DATE

CITY OF SOUTH ST. PAUL
TAXICAB INFORMATION

You are hereby notified that your Taxicab Driver's License will be issued, along with your license stickers, when this form is completed and returned to our office and upon Council approval.

PLEASE FURNISH THE FOLLOWING INFORMATION ON EACH TAXICAB TO BE LICENSED WITH THE CITY OF SOUTH ST. PAUL (attach additional sheets if necessary):

OWNER NAME: _____
OWNER ADDRESS: _____

MAKE: _____ MODEL: _____ YEAR: _____
ENGINE # _____ VIN # _____ STATE LICENSE NO.: _____
CURRENT, VALID TAXICAB LICENSE WITH THE CITY OF ST. PAUL? YES ___ NO ___

OWNER NAME: _____
OWNER ADDRESS: _____

MAKE: _____ MODEL: _____ YEAR: _____
ENGINE # _____ VIN # _____ STATE LICENSE NO.: _____
CURRENT, VALID TAXICAB LICENSE WITH THE CITY OF ST. PAUL? YES ___ NO ___

OWNER NAME: _____
OWNER ADDRESS: _____

MAKE: _____ MODEL: _____ YEAR: _____
ENGINE # _____ VIN # _____ STATE LICENSE NO.: _____
CURRENT, VALID TAXICAB LICENSE WITH THE CITY OF ST. PAUL? YES ___ NO ___

FOR EACH VEHICLE, SUBMIT AN INSPECTION CERTIFICATE THAT CONFIRMS THAT THE VEHICLE PASSED AN INSPECTION AT A QUALIFIED SERVICE STATION OR GARAGE THAT EMPLOYS A MASTER ASE (AUTOMOTIVE SERVICE EXCELLENCE) TECHNICIAN.

Certificate of Compliance Minnesota Workers' Compensation Law

THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT

PRINT IN INK or TYPE.

Minnesota Statutes, Section 176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, Chapter 176. If the required information is not provided or is falsely stated, it shall result in a \$2,000 penalty assessed against the applicant by the commissioner of the Department of Labor and Industry.

A valid workers' compensation policy must be kept in effect at all times by employers as required by law.

LICENSE or CERTIFICATE NO (if applicable)	BUSINESS TELEPHONE NO.	FAX TELEPHONE NO.
BUSINESS NAME (Use the person(s) name if business structure is sole proprietor or partnership (i.e., John Doe, or John Doe and Jane Doe), otherwise it is the legal name of the business entity.)		
DBA ("doing business as" or also known as an assumed name) (if applicable)		
BUSINESS ADDRESS (must be physical street address, no PO boxes)	CITY	STATE ZIP CODE
COUNTY	E-MAIL ADDRESS	

YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.*

NUMBER 1 – Workers' compensation insurance policy information

INSURANCE COMPANY NAME (not the insurance agent)	NAIC Number	
POLICY NO.	EFFECTIVE DATE	EXPIRATION DATE

NUMBER 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, contact 651.284.5032 or 1-800-342-5354.

- I have no employees. (See Minn. Stat. § 176.011, subd. 9 for the definition of an employee.)
- I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the Minnesota Department of Commerce).
- I have employees but they are not covered by the workers' compensation law. (See Minn. Stat. § 176.041 for a list of excluded employees.) Explain why your employees are not covered:

Other: _____

I certify that the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify that I am authorized to sign on behalf of the business.

PRINT NAME

APPLICANT SIGNATURE (required)	TITLE	DATE
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NOTE: You must notify us if there is any change to your Workers' Compensation Insurance Information or Employee Status Change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or on a tape.

**CITY OF SOUTH ST. PAUL
REQUIREMENTS FOR INSURANCE CERTIFICATES**

CERTIFICATE OF LIABILITY INSURANCE

PRODUCER Agency Address City, State, Zip	Certificate cannot be Pending, Binder or TBA.	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.
INSURED		INSURERS AFFORDING COVERAGE NAIC#
The Legal/Corporate Name must match exactly (word for word) to the Approved Licensee Name (including Inc, or LLC), Trade Name (DBA), and Premise address.	INSURER A: INSURER B: INSURER C: INSURER D: INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAME 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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)				LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC							EACH OCCURRENCE \$ DAMAGE TO RENTED \$ PREMISES (ea occurrence) MED EXP (any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS-COMP/OP AGG \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS							COMBINED SINGLE LIMIT \$ (ea accident) BODILY INJURY \$ (per person) BODILY INJURY \$ (per accident) PROPERTY DAMAGE \$ (per accident)
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO							AUTO ONLY-EA ACCIDENT \$ OTHER THAN EA ACC \$ AUTO ONLY: AGG \$
	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$							EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below							<input type="checkbox"/> WC STATU- <input type="checkbox"/> OTHER TORY LIMITS E.L. EACH ACCIDENT \$ E.L. DISEASE-EA EMPLOYEE \$ E.L. DISEASE-POLICY LIMIT \$
	OTHER LIQUOR LIABILITY							

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER CITY OF SOUTH ST. PAUL 125 3RD AVENUE NORTH SOUTH ST. PAUL, MN 55075	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>30</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE Original Signature or stamp of Agent
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