



AMERICAN SPECIALTY™ INCIDENT REPORT INSTRUCTIONS

Whenever an Accident Occurs:

An incident report must be completed immediately and mailed to the address shown below. This holds true whether the person involved is a participant or a spectator, or whether or not you feel the incident will result in a claim.

Although you may not have sufficient information to answer all the questions, it is important that the form be completed as fully as possible. Do not delay sending in the report form; an incomplete form is better than none at all. Always include your name and daytime telephone number where indicated on the form.

The form contains sections to capture information regarding injury to persons, damage to property, and accidents involving autos.

If you have any questions regarding completion of the form, please call American Specialty Insurance Services at 1-800-245-2744.

Mail the completed report to:

American Specialty Insurance & Risk Services, Inc.
ATTN: Claims Department
142 N. Main Street, P.O. Box 459
Roanoke, IN 46783-0309
Phone:(800) 566-7941 Fax:(260) 672-8835

In case of serious injury, immediately notify American Specialty by calling 1-800-566-7941 (if after hours, follow the instructions for emergency claims reporting). This number is answered 24 hours a day, 365 days a year. It is important that you contact this claim line as soon as possible after a serious injury involving a participant or spectator.

LEAGUE OF AMERICAN BICYCLISTS

FIRST REPORT OF BODILY INJURY



AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
 ATTN: CLAIMS DEPARTMENT
 142 N. MAIN STREET, P.O. BOX 459
 ROANOKE, IN 46783
 PHONE: 800-566-7941 FAX: 260-673-1189

Date of Incident: _____ Time of Incident: _____ AM / PM If injured person is an L.A.B. member, identify: L.A.B. Club Name: _____ Club Address: _____	Does the Injured Person Have Other Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: Name of company: _____ Policy #: _____
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Injured Person: <input type="checkbox"/> Club Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Participant <input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____ Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the injured person riding: <input type="checkbox"/> Tandem Bike <input type="checkbox"/> Single Bike	Did This Take Place During: <input type="checkbox"/> Club Ride <input type="checkbox"/> Special Event <input type="checkbox"/> Time Trial <input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event <input type="checkbox"/> Fundraiser If during a Special Event, list name of event: _____ Name of L.A.B. Club putting on the Special Event: _____
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INJURED PERSON INFORMATION

Last Name _____ First _____ Mid. _____ Address _____ City _____ Age _____ D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number () _____ <input type="checkbox"/> Single <input type="checkbox"/> Married Social Security Number: _____ Employer Name: _____ Employer Address: _____
GUARDIAN/PARENT (if injured person is a minor)	
Last Name _____ First _____ Mid. _____ Address _____ City _____ State _____ Zip _____	Telephone Number () _____

SUSPECTED PRE-EXISTING CONDITION: Yes No

INCIDENT LOCATION <input type="checkbox"/> Off Road <input type="checkbox"/> City Street <input type="checkbox"/> Parking Lot <input type="checkbox"/> Highway <input type="checkbox"/> Registration Area <input type="checkbox"/> Rural Road <input type="checkbox"/> Restrooms/Locker Rooms <input type="checkbox"/> Off Property <input type="checkbox"/> Premises/Grounds <input type="checkbox"/> Rest Stop	INCIDENT <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Overexertion <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Eligibility <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Trip/fall <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Slip/fall <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Animal/Insect Bite/Sting <input type="checkbox"/> Chased by dog <input type="checkbox"/> Collision (with parked car) <input type="checkbox"/> Bit by dog <input type="checkbox"/> Collision (with moving car) <input type="checkbox"/> Collision (with object/animal) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Auto/property (also complete reverse side)	WEATHER CONDITIONS <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy
RIDER ACTIVITY <input type="checkbox"/> Turning right <input type="checkbox"/> Passing <input type="checkbox"/> Turning left <input type="checkbox"/> Intersection <input type="checkbox"/> Being passed <input type="checkbox"/> Straight		ROAD CONDITIONS <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy
CLASSIFICATION <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness		ROAD TYPE <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel
PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea <input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Stroke <input type="checkbox"/> Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Death <input type="checkbox"/> Drowning <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth	BODY PARTY INJURED <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe	DISPOSITION <input type="checkbox"/> Released to parent <input type="checkbox"/> Police <input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report Only <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Continued riding <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Refer to hospital/clinic

Describe how the incident occurred: _____

WITNESS INFORMATION		
NAME	ADDRESS	TELEPHONE NUMBER
1.		()
2.		()

Signature of Ride Leader or Official (with no relationship to claimant) _____
 Date _____ Phone Number _____



FIRST REPORT OF AUTO ACCIDENT

If the injury or property damage was the result of an AUTO ACCIDENT, please complete this section:

PERSON DRIVING THE AUTO: _____ Injured Not injured
Address: _____

OWNER OF THE AUTO: _____
Address: _____

MAKE/MODEL/YEAR OF AUTO: _____

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN THE AUTO:

Name: _____ Injured Not injured
Address: _____

Name: _____ Injured Not injured
Address: _____

NOTE: PLEASE USE THE REVERSE SIDE OF THIS FORM TO PROVIDE INJURY INFORMATION. A LIST OF ALL PASSENGERS AND INJURY INFORMATION FOR ALL INJURED PERSONS SHOULD BE PROVIDED; PLEASE USE ADDITIONAL INCIDENT REPORT FORMS OR SEPARATE SHEETS OF PAPER, IF NECESSARY.

PURPOSE OF TRIP: _____

NAME OF POLICE DEPARTMENT WHICH INVESTIGATED THE ACCIDENT: _____

If the accident involved a collision with another automobile, please complete the following:

PERSON DRIVING OTHER AUTO: _____ Injured Not-injured
Address: _____

OWNER OF OTHER AUTO: _____
Address: _____

MAKE/MODEL/YEAR OF OTHER AUTO: _____

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN OTHER AUTO:

Name: _____ Injured Not injured
Address: _____

Name: _____ Injured Not injured
Address: _____

(Attach separate sheet of paper, if necessary.)

FIRST REPORT OF PROPERTY DAMAGE

(OTHER THAN AUTO ACCIDENTS)

If property was damaged, please supply a description of the property and list the owner. (If an auto accident, see above.)

Description of property: _____

Description of damage: _____

Owner's name and address: _____

Owner's telephone number: () (day) () (evening)