

## 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 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

American Specialty Insurance 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

## FIRST REPORT OF BODILY INJURY/AUTO ACCIDENT/PROPERTY DAMAGE

<b>DATE OF INCIDENT</b> _____ <b>TIME OF INCIDENT</b> _____ <b>AM/PM</b> If injured person is an L.A.B. club member, identify: L.A.B. Club Name: _____ Club Address: _____	<b>DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide name of company and policy# _____
<b>INJURED PERSON:</b> <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	<b>DID THIS TAKE PLACE DURING:</b> <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: _____

INJURED PERSON INFORMATION			
<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number ( )</b>
			<input type="checkbox"/> Single <input type="checkbox"/> Married
<b>Address</b>		<b>Social Security Number</b>	
<b>City</b>	<b>State</b>	<b>Employer and Address</b>	
<b>Age</b>	<b>D.O.B.</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)			
<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number ( )</b>
<b>Address</b>		<b>City</b>	<b>State</b>
		<b>State</b>	<b>Zip</b>

SUSPECTED PRE-EXISTING CONDITION: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>INCIDENT LOCATION</b> <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 <hr/> <b>RIDER ACTIVITY</b> <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 <hr/> <b>CLASSIFICATION</b> <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness	<b>INCIDENT</b> <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"/> Bite 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)	<b>WEATHER CONDITIONS</b> <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy <hr/> <b>ROAD CONDITIONS</b> <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy <hr/> <b>ROAD TYPE</b> <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel

<b>PRIMARY INJURY</b> <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"/> Cardiac <input type="checkbox"/> Illness <input type="checkbox"/> Cold injury <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/mouth	<b>BODY PART INJURED</b> <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	<b>DISPOSITION</b> <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"/> Refer to hospital/clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Continued riding
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**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 #** \_\_\_\_\_

**LEAGUE OF AMERICAN BICYCLISTS  
FIRST REPORT OF AUTO ACCIDENT OR PROPERTY DAMAGE**

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: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Injured     Not injured                       Injured     Not injured

NOTE: PLEASE USE THE REVERSE SIDE OF THIS FORM TO SUPPLY INJURY INFORMATION. A LIST OF ALL PASSENGERS AND INJURY INFORMATION FOR ALL INJURED PERSONS SHOULD BE SUPPLIED; 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 also 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: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Injured     Not injured                       Injured     Not injured

(Attach separate sheet of paper, if necessary.)

**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 reverse side.)

Description of property: \_\_\_\_\_

Description of damage: \_\_\_\_\_

Owner's name and address: \_\_\_\_\_

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