



AMERICAN SPECIALTY®

Proud Sponsor of America's Pastimes and Future Times®

INCIDENT REPORTING INSTRUCTIONS

Whenever an Accident Occurs:

An Incident Report form must be completed immediately after an accident occurs and mailed or faxed to American Specialty Insurance & Risk Services, Inc. as indicated 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 initially answer all questions, it is important that the form be completed as fully as possible at the time of the accident. Do not delay sending in the report form; an incomplete form is better than none at all. Be certain to 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 or need assistance regarding the completion of the Incident Report form, please call American Specialty at 1-800-245-2744.

Mail or fax the completed Incident Report to:

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.

Attn: Claims Department
Post Office Box 459
Roanoke, Indiana 46783-0459

Fax: (260) 673-1291

IN ADDITION, IN CASE OF SERIOUS INJURY TO A PARTICIPANT OR A SPECTATOR, it is important that you immediately notify American Specialty by calling 1-800-566-7941 (if after standard business hours, simply follow the automated instructions for emergency claims reporting). This hotline is active 24 hours a day, 365 days a year.



INCIDENT REPORT FORM FOR BODILY INJURY

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.



ATTN: CLAIMS DEPARTMENT

POST OFFICE BOX 459

ROANOKE, IN 46783

PHONE: 800-566-7941 FAX: 260-673-1291

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? Yes No If yes, please provide: Name of company: _____ Policy #: _____
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Injured Person: Club Member Non-Member Participant Volunteer Pedestrian Other _____ Was the injured person wearing a helmet at the time of the accident? Yes No Was the injured person riding: Tandem Bike Single Bike	Did This Take Place During: Club Ride Special Event Time Trial Race Conditioning Event 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. Telephone Number () Single Married
Address Social Security Number:
City Employer Name:
Age D.O.B. Male Female Employer Address:

GUARDIAN/PARENT (if injured person is a minor)

Last Name First Mid. Telephone Number ()
Address City State Zip

SUSPECTED PRE-EXISTING CONDITION: Yes No

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

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 _____

**AMERICAN SPECIALTY
EMERGENCY CLAIMS SERVICE**

**1-800-566-7941
(24-Hours/7-Days a Week)**

For All Claims Emergencies

Please immediately report by **PHONE** all incidents that **result in serious injury or death.**

Please complete an Incident Report form for **ANY** incident that results in death, serious injury and/or bodily injury, automobile, or property damage, and forward via mail or fax the completed form to:

**American Specialty Insurance & Risk Services, Inc.
Post Office Box 459
Roanoke, IN 46783-0459
Fax: (260) 673-1291**