



AMERICAN SPECIALTY®

INSURING 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 1-800-566-7941.

Mail or fax the completed Incident Report to:

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.

7609 W. Jefferson Boulevard

Suite 150

Fort Wayne, Indiana 46804-4133

Fax: 260.969.4729

**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.

7609 W. Jefferson Blvd., Suite 150

Fort Wayne, Indiana 46804-4133

Phone: 800.566.7941 | Fax: 260.969.4729



|  |   |
|--|---|
| <b>Date of Incident:</b> _____ <b>Time of Incident:</b> _____ AM / PM<br>If injured person is a League member, identify:<br><b>League Club Name:</b> _____<br><b>Club Address:</b> _____ | <b>Does the Injured Person Have Other Medical Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please provide:<br><b>Name of company:</b> _____<br><b>Policy #:</b> _____ |
|--|---|

|   |  |
|---|--|
| <b>Injured Person:</b> <input type="checkbox"/> Club Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Participant<br><input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____<br><br>Was the injured person wearing a helmet at the time of the accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>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<br><input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event <input type="checkbox"/> Fundraiser <input type="checkbox"/> Mountain Bike Ride<br>If during a Special Event, list name of event: _____<br><br>Name of League Club putting on the Special Event: _____ |
|---|--|

| INJURED PERSON INFORMATION   |   |
|--|---|
| Last Name _____ First _____ Mid. _____   | Telephone Number ( ) _____ <input type="checkbox"/> Single <input type="checkbox"/> Married |
| Address _____  |   |
| City _____   |   |
| Age _____ D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security Number (optional): _____  |
| Employer Name: _____   |   |
| 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

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

Please provide the name/email address of the individual that will be responsible for verifying claim information in the event of an incident (if different from above).

NAME \_\_\_\_\_ EMAIL: \_\_\_\_\_



# INCIDENT REPORT FORM FOR AUTO ACCIDENT AND PROPERTY DAMAGE

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.  
7609 W. Jefferson Blvd., Suite 150  
Fort Wayne, Indiana 46804-4133  
Phone: 800-566-7941 | Fax: 260.969.4729



## 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 THIS SECTION:

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.)*

## IF THE ACCIDENT INVOLVED PROPERTY DAMAGE (OTHER THAN AUTOMOBILES), PLEASE COMPLETE THIS SECTION:

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

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

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

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

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