



AMERICAN SPECIALTY®

INSURING AMERICA'S PASTIMES AND FUTURE TIMES®

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## 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) 672-8835

**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: 260-672-8835



<b>Date of Incident:</b> _____ <b>Time of Incident:</b> _____ <b>AM / PM</b> If injured person is a League member, identify: <b>League Club Name:</b> _____ <b>Club Address:</b> _____	<b>Does the Injured Person Have Other Medical Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: <b>Name of company:</b> _____ <b>Policy #:</b> _____
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<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 League Club putting on the Special Event: _____ _____
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INJURED PERSON INFORMATION	
Last Name _____ First _____ Mid. _____	Telephone Number ( ) _____ <input type="checkbox"/> Single <input type="checkbox"/> Married
Address _____	Social Security Number (optional): _____
City _____	Employer Name: _____
Age _____ D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> 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

<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	<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"/> Bit by dog <input type="checkbox"/> Collision (with moving car) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (with object/animal)  <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Struck by falling/flying object	<b>WEATHER CONDITIONS</b> <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy
<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	<input type="checkbox"/> Auto/property (also complete reverse side of this form)	<b>ROAD CONDITIONS</b> <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy
<b>CLASSIFICATION</b> <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness		<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"/> 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	<b>BODY PARTY 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"/> 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
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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 Number \_\_\_\_\_



# INCIDENT REPORT FORM FOR AUTO ACCIDENT AND PROPERTY DAMAGE

American Specialty Insurance & Risk Services, Inc.  
Attn: Claims Department  
Post Office Box 459  
Roanoke, IN 46783  
Phone: 800-566-7941 Fax: 260-672-8835



## 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)

**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) 672-8835**