



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: (219) 672-8835

FIRST REPORT OF BODILY INJURY/AUTO ACCIDENT/PROPERTY DAMAGE

<p>DATE OF INCIDENT _____</p> <p>TIME OF INCIDENT _____ AM/PM</p> <p>If injured person is a LAB club member, identify LAB Club:</p> <p>Name: _____</p> <p>Club Address: _____</p> <p>_____</p>	<p>DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, please provide name of company and policy #:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>INJURED PERSON: <input type="checkbox"/> Club Member <input type="checkbox"/> Non-member</p> <p><input type="checkbox"/> Participant <input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Other _____</p> <p>Was the injured person wearing a helmet at the time of the accident?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the injured person riding:</p> <p><input type="checkbox"/> Tandem Bike <input type="checkbox"/> Single Bike</p>	<p>DID THIS TAKE PLACE DURING: <input type="checkbox"/> Club Ride</p> <p><input type="checkbox"/> Special Event <input type="checkbox"/> Time Trial <input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event</p> <p><input type="checkbox"/> Fundraiser</p> <p>If during a Special Event, list name of event:</p> <p>_____</p> <p>Name of LAB Club putting on the Special Event:</p> <p>_____</p>

INJURED PERSON INFORMATION

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

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name	First	Middle	Telephone Number ()
Address	City	State	Zip

SUSPECTED PRE-EXISTING CONDITION: Yes No

<p>INCIDENT LOCATION</p> <p><input type="checkbox"/>Off-road <input type="checkbox"/>City street</p> <p><input type="checkbox"/>Parking lot <input type="checkbox"/>Highway</p> <p><input type="checkbox"/>Registration area <input type="checkbox"/>Rural road</p> <p><input type="checkbox"/>Restrooms/locker rooms <input type="checkbox"/>Off property</p> <p><input type="checkbox"/>Premises/grounds <input type="checkbox"/>Rest stop</p> <p>RIDER ACTIVITY</p> <p><input type="checkbox"/>Turning right <input type="checkbox"/>Passing</p> <p><input type="checkbox"/>Turning left <input type="checkbox"/>Intersection</p> <p><input type="checkbox"/>Being passed <input type="checkbox"/>Straight</p> <p>CLASSIFICATION</p> <p><input type="checkbox"/>Minor injury or illness <input type="checkbox"/>Non-injury</p> <p><input type="checkbox"/>Serious injury or illness</p>	<p>INCIDENT</p> <p><input type="checkbox"/>Assault/sexual <input type="checkbox"/>Overexertion</p> <p><input type="checkbox"/>Assault/non-sexual <input type="checkbox"/>Eligibility</p> <p><input type="checkbox"/>Fall (different level) <input type="checkbox"/>Trip/fall</p> <p><input type="checkbox"/>Fall (same level) <input type="checkbox"/>Slip/fall</p> <p><input type="checkbox"/>Caught in, on, between</p> <p><input type="checkbox"/>Slip, bodily reaction</p> <p><input type="checkbox"/>Animal/insect bite/sting <input type="checkbox"/>Chased by dog</p> <p><input type="checkbox"/>Collision (with parked car) <input type="checkbox"/>Bite by dog</p> <p><input type="checkbox"/>Collision (with moving car)</p> <p><input type="checkbox"/>Collision (with object/animal)</p> <p><input type="checkbox"/>Collision (participant/participant)</p> <p><input type="checkbox"/>Collision (participant/pedestrian)</p> <p><input type="checkbox"/>Struck by falling/flying object</p> <p><input type="checkbox"/>Auto/property (also complete reverse side)</p>	<p>WEATHER CONDITIONS</p> <p><input type="checkbox"/>Sunny <input type="checkbox"/>Raining</p> <p><input type="checkbox"/>Foggy</p> <p><input type="checkbox"/>Snowing <input type="checkbox"/>Cloudy</p> <p>ROAD CONDITIONS</p> <p><input type="checkbox"/>Wet <input type="checkbox"/>Dry <input type="checkbox"/>Icy</p> <p>ROAD TYPE</p> <p><input type="checkbox"/>Paved <input type="checkbox"/>Dirt <input type="checkbox"/>Gravel</p>
<p>PRIMARY INJURY</p> <p><input type="checkbox"/>Allergy <input type="checkbox"/>Dislocation</p> <p><input type="checkbox"/>Nausea <input type="checkbox"/>Sting/bite</p> <p><input type="checkbox"/>Amputation <input type="checkbox"/>Electrical shock</p> <p><input type="checkbox"/>Stroke</p> <p><input type="checkbox"/>Abrasion <input type="checkbox"/>Foreign body <input type="checkbox"/>Burn</p> <p><input type="checkbox"/>Laceration <input type="checkbox"/>Fracture <input type="checkbox"/>Death</p> <p><input type="checkbox"/>Drowning <input type="checkbox"/>Heat exhaustion <input type="checkbox"/>Pain</p> <p><input type="checkbox"/>Hypertension <input type="checkbox"/>Cardiac <input type="checkbox"/>Illness</p> <p><input type="checkbox"/>Cold injury <input type="checkbox"/>Contusion</p> <p><input type="checkbox"/>Seizures <input type="checkbox"/>Concussion</p> <p><input type="checkbox"/>Strain/Sprain <input type="checkbox"/>Tooth/mouth</p>	<p>BODY PART INJURED</p> <p><input type="checkbox"/>Eye (L/R) Torso <input type="checkbox"/>Arm (L/R)</p> <p><input type="checkbox"/>Nose <input type="checkbox"/>Back <input type="checkbox"/>Tooth</p> <p><input type="checkbox"/>Neck <input type="checkbox"/>Face <input type="checkbox"/>Head</p> <p><input type="checkbox"/>Ear (L/R) <input type="checkbox"/>Leg (L/R)</p> <p><input type="checkbox"/>Knee (L/R) <input type="checkbox"/>Ankle (L/R)</p> <p><input type="checkbox"/>Internal <input type="checkbox"/>Hip (L/R)</p> <p><input type="checkbox"/>Shoulder (L/R) <input type="checkbox"/>Foot (L/R)</p> <p><input type="checkbox"/>Elbow (L/R) <input type="checkbox"/>Hand (L/R)</p> <p><input type="checkbox"/>Wrist (L/R) <input type="checkbox"/>Finger or Toe</p>	<p>DISPOSITION</p> <p><input type="checkbox"/>Released to parent</p> <p><input type="checkbox"/>Police</p> <p><input type="checkbox"/>Refusal of care</p> <p><input type="checkbox"/>Ambulance</p> <p><input type="checkbox"/>Refer to doctor</p> <p><input type="checkbox"/>Report only</p> <p><input type="checkbox"/>Refer to hospital/clinic</p> <p><input type="checkbox"/>Medical attention</p> <p><input type="checkbox"/>EMS transport</p> <p><input type="checkbox"/>Patient requested EMS transport</p> <p><input type="checkbox"/>Released to personal vehicle</p> <p><input type="checkbox"/>Continued riding</p>
<p>Describe how the incident occurred:</p>		

WITNESS INFORMATION

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

Signature of Ride Leader or Official (with no relationship to claimant)

_____ DATE _____ Phone # () _____