



League of American Bicyclists

AMERICAN SPECIALTY™

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

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

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

INCIDENT LOCATION <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 RIDER ACTIVITY <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 CLASSIFICATION <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness	INCIDENT <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)	WEATHER CONDITIONS <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy ROAD CONDITIONS <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy ROAD TYPE <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel
PRIMARY INJURY <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	BODY PART INJURED <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"/> Internal <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Finger or Toe	DISPOSITION <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

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)