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**

**Date of Incident:** __________  **Time of Incident:** ________ AM / PM

If injured person is a League member, identify:
League Club Name: __________
Club Address: __________

<table>
<thead>
<tr>
<th>Suspected Pre-Existing Condition</th>
<th>__________</th>
<th>__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Condition:</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

**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

**GUARDIAN/PARENT (if injured person is a minor)**
Last Name: __________  First: __________  Mid: __________  Telephone Number: (_________)

**Employer Name:** __________  Employer Address: __________

**City Employer Name:** __________  Address Social Security Number (optional): __________

**Was the injured person riding:**
[ ] Turning right  [ ] Passing  [ ] Turning left  [ ] Intersection  
[ ] Being passed  [ ] Straight

**Rider Activity:**
[ ] Collision (participant/roadway)  [ ] Collision (participant/pedestrian)  
[ ] Struck by falling/flying object

**Injured Person Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Mid</th>
<th>Telephone Number</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>_______</td>
<td>_____</td>
<td>(_________)</td>
<td>__________</td>
</tr>
</tbody>
</table>

**GUARDIAN/PARENT (if injured person is a minor)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Mid</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>_______</td>
<td>_____</td>
<td>(_________)</td>
</tr>
</tbody>
</table>

**Suspected Pre-Existing Condition:**  [ ] Yes  [ ] No

**Date of Incident:** __________  **Time of Incident:** ________ AM / PM

**Injured Person:**  
[ ] Club Member  [ ] Non-Member  [ ] Participant  
[ ] Volunteer  [ ] Pedestrian  [ ] Other  __________

**Incident Location:**
[ ] Off Road  [ ] City Street  [ ] Parking Lot  [ ] Highway  
[ ] Registration Area  [ ] Rural Road  [ ] Restrooms/Locker Rooms  [ ] Off Property  
[ ] Premises/Grounds  [ ] Rest Stop

**Rider Activity:**
[ ] Turning right  [ ] Passing  [ ] Turning left  [ ] Intersection  
[ ] Being passed  [ ] Straight

**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/roadway)  [ ] Collision (participant/pedestrian)  
[ ] Auto/property (also complete reverse side of this form)

**Weather Conditions:**
[ ] Sunny  [ ] Foggy  [ ] Snowing  [ ] Cloudy

**Road Conditions:**
[ ] Wet  [ ] Dry  [ ] Icy

**Road Type:**
[ ] Paved  [ ] Dirt  [ ] Gravel

**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  [ ] Cardiac  
[ ] Strain/Sprain  [ ] Tooth/Mouth

**Primary Injury:**
[ ] Eye (L/R)  [ ] Nose  [ ] Neck  [ ] Ear (L/R)  
[ ] Neck  [ ] Face  [ ] Ear (R/L)  [ ] Ankle (L/R)  
[ ] Knee (L/R)  [ ] Hip (L/R)  [ ] Shoulder (L/R)  [ ] Foot (L/R)  
[ ] Elbow (L/R)  [ ] Hand (L/R)  [ ] Wrist (L/R)  [ ] Finger or Toe

**Body Party Injured:**
[ ] Torso  [ ] Back  [ ] Arm (L/R)  [ ] Arm (R/L)  
[ ] Torso  [ ] Back  [ ] Head  [ ] Head

**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

**Describ how the incident occurred:**

**Witness Information**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>(_________)</td>
<td>(_________)</td>
</tr>
</tbody>
</table>

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

Date __________  Phone Number __________

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"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"
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### INCIDENT REPORT FORM
FOR AUTO ACCIDENT
AND PROPERTY DAMAGE

#### IF THE INJURY OR PROPERTY DAMAGE WAS THE RESULT OF AN AUTO ACCIDENT, PLEASE COMPLETE THIS SECTION:

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSON DRIVING THE AUTO:</td>
<td>☐ Injured ☐ Not injured</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>OWNER OF THE AUTO:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>MAKE/MODEL/YEAR OF AUTO:</td>
<td></td>
</tr>
<tr>
<td>LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN THE AUTO:</td>
<td>☐ Injured ☐ Not injured</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF TRIP:</td>
<td></td>
</tr>
<tr>
<td>NAME OF POLICE DEPARTMENT WHICH INVESTIGATED THE ACCIDENT:</td>
<td></td>
</tr>
</tbody>
</table>

#### IF THE ACCIDENT INVOLVED A COLLISION WITH ANOTHER AUTOMOBILE, PLEASE COMPLETE THIS SECTION:

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSON DRIVING OTHER AUTO:</td>
<td>☐ Injured ☐ Not-injured</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>OWNER OF OTHER AUTO:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>MAKE/MODEL/YEAR OF OTHER AUTO:</td>
<td></td>
</tr>
<tr>
<td>LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN OTHER AUTO:</td>
<td>☐ Injured ☐ Not injured</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

(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.)

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of property:</td>
<td></td>
</tr>
<tr>
<td>Description of damage:</td>
<td></td>
</tr>
<tr>
<td>Owner's name and address:</td>
<td></td>
</tr>
<tr>
<td>Owner's telephone number:</td>
<td>(____<strong><strong>)</strong></strong>_________________ (day) (____<strong><strong>)</strong></strong>_________________ (evening)</td>
</tr>
</tbody>
</table>
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 resulting in death, serious injury and/or bodily injury, automobile damage, or property damage, and forward the completed form by fax or by mail to:

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. JEFFERSON BLVD., SUITE 150
FORT WAYNE, INDIANA 46804-4133
FAX: 260.969.4729