AMERICAN SPECIALTY™

League of American Bicyclists
ATTN: Claims Department
142 N. Main Street, P.O. Box 459
Roanoke, IN 46783-0309

American Specialty Insurance Services, Inc.

Phone: (800) 566-7941 Fax: (260) 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: Grizzly Peak Cyclists
Club Address: P. O. Box 9308
Berkeley, CA 94709

DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? ☐ **YES** ☐ **NO**
If yes, please provide name of company and policy#_____
_____

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

DID THIS TAKE PLACE DURING: ☐ Club Ride ☐ Special Event
☐ Time Trial ☐ Race ☐ Conditioning Event ☐ 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 ( )** ☐ **Single** ☐ **Married**
Address			**Social Security Number**
City	**State**	**Zip**	**Employer and Address**
Age	**D.O.B.**	☐ **Male** ☐ **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
☐ 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

CLASSIFICATION
☐ Minor injury or illness ☐ Non-injury
☐ Serious injury or illness

INCIDENT
☐ Assault/sexual ☐ Overexertion
☐ Assault/non-sexual ☐ Eligibility
☐ Fall (different level) ☐ Trip/fall
☐ Fall (same level) ☐ Slip/fall
☐ Caught in, on, between ☐ Slip, bodily reaction
☐ Animal/insect bite/sting ☐ Chased by dog
☐ Collision (with parked car) ☐ Bite by dog
☐ Collision (with moving car)
☐ Collision (with object/animal)
☐ Collision (participant/participant)
☐ Collision (participant/pedestrian)
☐ Struck by falling/flying object
☐ Auto/property (also complete reverse side)

WEATHER CONDITIONS
☐ Sunny ☐ Raining
☐ 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 ☐ Cardiac ☐ Illness
☐ Cold injury ☐ Contusion ☐ Sting/bite
☐ Seizures ☐ Concussion
☐ Strain/Sprain ☐ Tooth/mouth

BODY PART INJURED
☐ Eye (L/R) ☐ Torso ☐ Arm (L/R)
☐ Nose ☐ Back ☐ Tooth
☐ Neck ☐ Face ☐ Head
☐ Ear (L/R) ☐ Leg (L/R)
☐ Knee (L/R) ☐ Ankle (L/R)
☐ Internal ☐ Hip (L/R)
☐ Shoulder (L/R) ☐ Foot (L/R)
☐ Elbow (L/R) ☐ Hand (L/R)
☐ Wrist (L/R) ☐ Finger or Toe

DISPOSITION
☐ Released to parent ☐ Police
☐ Refusal of care ☐ Ambulance
☐ Refer to doctor ☐ Report only
☐ Refer to hospital/clinic
☐ Medical attention
☐ EMS transport
☐ Patient requested EMS transport
☐ Released to personal vehicle
☐ 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)