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 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: ________________________________

Does the Injured Person Have Other Medical Insurance? Yes No
If yes, please provide:
Name of company: ____________________________
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 League Club putting on the Special Event: ____________________________

INJURED PERSON INFORMATION

Last Name First Mid. Telephone Number ( ) Single Married
Address ________________________________
City ________________________________
Age D.O.B. ________ Male Female
Employer Name: ________________________________
Employer Address: ________________________________

GUARDIAN/PARENT (if injured person is a minor)

Last Name First Mid. Telephone Number ( )
Address ________________________________
City ________________________________
State ________________________________
Zip ________________________________

SUPESTED PRE-EXISTING CONDITION: Yes No

INCIDENT LOCATION

Off Road City Street
Parking Lot Highway
Registration Area Rural Road
Restrooms/Locker Rooms Off Property
Fremises/Grounds Rest Stop

IDENTIFICATION

RIDER ACTIVITY

Turning right Passing
Turning left Intersection
Being passed Straight

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) Bit by dog
Collision (with moving car) Collision (participant/participant)
Collision (object/animal) Auto/property (also complete reverse side of this form)

CLASSIFICATION

Minor injury or illness Non-injury
Serious injury or illness

PRIOARY INJURY

Allergy Dislocation Nausea
Amputation Electrical Shock Stroke
Abrasion Foreign Body Burn
Laceration Fracture Death
Drowning Heat Exhaustion Pain
Hypertension Sling/Bite Illness
Cold Injury Conussion Cardiac
Seizures Concussion
Strain/Sprain Tooth/Mouth

BODY PARTY 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

WEATHER CONDITIONS

Sunny Rain/Snow
Foggy Snowing
Cloudy

ROAD CONDITIONS

Wet Dry
Icy

ROAD TYPE

Paved Dirt
Gravel

WEIGHT/DISPONITION

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

DESCRIBE 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>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Date ___________ Phone Number ___________ Email: ________________________________

Please provide the name/email address of the individual that will be responsible for verifying claim information in the event of an incident (if different from above).

NAME ____________________________ EMAIL: ________________________________