FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# ZC-2837

PRIMARY CARRIER
Company Code [0|1|2|9|0] (Florida Certificate of Authority Number)

Company Name Employers Fire Insurance Co. 80 10371

Policy Number FX-2675-25

EXCESS CARRIER
Company Code [| | | |] (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed [8 0] FCC [M|M|1] IAC [3]

Insured Stephen M. Harris, M. D.

Address 401 Coral Way, Coral Gables, FL County Code [0|1]

(1) Speciality Psychiatry Code [1 9]

(2) Date of Incident (Month, Day, Year) [1|2|3|1|7|0]

(3) Date submitted for mediation (Month, Day, Year) [| | | | |]

(4) Disposition of mediation (check one):

(1) [ ] Plaintiff (2) [x] Defendant (3) [ ] No final conclusion

(5) Date of suit, if filed (Month, Day, Year) [0|6|0|7|8]

(6) Disposition of incident (check one):

(1) [ ] Final Judgment (2) [ ] Settlement

(3) [x] Final Disposition Not Resulting in Payment on Behalf of the Insured

(7) Date and amount of Judgment or Settlement (Month, Day, Year) [| | | | |]

A. Primary Indemnity $ ~~Nil~~ 0 C. Excess Indemnity $ _____

B. Primary Defense $ 950.00 D. Excess Defense Costs $ _____

(8) Summary Judgment (1) [ ] For Plaintiff (2) [ ] For Defendant

(9) Directed Verdict (1) [ ] For Plaintiff (2) [ ] For Defendant

(10) Trial (1) [ ] YES (2) [ ] NO

(11) Date and reason for final disposition, if no settlement or judgment:

(Month, Day, Year) [1|1|2|1|7|8] No further activity.

(12) Include brief summary of occurrence which created claim.
Alleges emotional distress following four years of treatment.

Prepared by [signature]

MM) 1-01/80