FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# 82-3427

00441

PRIMARY CARRIER
Company Code [4|4|0|5|0] (Florida Certificate of Authority Number)

Company Name PHYSICIANS PROTECTIVE TRUST FUND

Policy Number 3533

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

Company Name ______

Policy Number ______

Calendar Year Claim Closed [8|2] FCC [M|M|1] IAC [3]

Insured John Acevedo, M.D.

Address 10868 N. W. 21st Place, Coral Springs, FL

County Code [1|0]

(1) Speciality Anesthesia Code [0|1]

(2) Date of Incident (Month, Day, Year) [0|9|0|3|8|1]

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

(4) Disposition of mediation (check one):

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

(5) Date of suit, if filed (Month, Day, Year) [| | | | |]

(6) Disposition of incident (check one):

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

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

(7) Date and amount of Judgment or Settlement (Month, Day, Year) [0|9|2|1|8|2]

A. Primary Indemnity $ 150 ______ C. Excess Indemnity $ ______

B. Primary Defense $ 0 ______ 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) [X] NO

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

(Month, Day, Year) [1|0|1|8|8|2]

12) Include brief summary of occurrence which created claim on back.

Form No. DI4-303

Prepared by Sergio Moreno/cg

Tooth loosened during surgery.