FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# _____

PRIMARY CARRIER
Company Code [6][1][4][7][0] (Florida Certificate of Authority Number) 83

0476

Company Name THE ST. PAUL INSURANCE COMPANIES

Policy Number 509JT8675 09C001

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

Company Name _____

Policy Number _____

Calendar Year Claim Closed [8][3] FCC [H][M][I] IAC [3]

Insured Dr Robert S. Zeitler, M.D.

Address 1510 Barry St. Clearwater Fl 33518 County C[0][4]

1) Speciality Psychiatry Code [1][9]

2) Date of Incident (Month, Day, Year) [0][5][0][7][8][2]

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) [1][0][0][5][8][2]

6) Disposition of incident (check one):

(1) ☐ Final Judgment (2) ☐ Settlement

(3) ☒ 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 $ ~~None~~ 0 C. Excess Indemnity $ _____

B. Primary Defense $ 254** 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][0][2][8][2] Voluntary dismissal

allegd mistreatment of mental illness.

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

M)1-01/80 Prepared by W. M. Spencer