FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

95C1668

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 509JL095 1
09A001

1. PRIMARY INSURER NAME: St. Paul Fire & Marine Ins. INSURER CODE: 01470 (See Table A)

2. EXCESS INSURER NAME: _____ INSURER CODE: _____ (See Table A)

3. INSURED'S NAME: Antoine J. Innocent (last name, first name, middle name)
STREET ADDRESS: Rt. 3 Box 540
CITY, STATE: Stark, Fl. ZIP: 32091 COUNTY CODE: 45 (See Table B)

4. PRIMARY POLICY NUMBER: 509JL095 1
PRIMARY POLICY LIMITS: $ 250,000 .00 (per claim)
$ 750,000 .00 (per aggregate)
EXCESS POLICY NUMBER: _____
EXCESS POLICY LIMITS: $ _____ .00 (per claim)
$ _____ .00 (per aggregate)

5. Is the insured physician a Foreign Medical Graduate? ___ (1) Yes ___ (2) No
If yes, enter the country in which primary medical education was received: _____

6. PROFESSION OR BUSINESS: (check one)
X (1) Physicians & Surgeons
___ (2) Hospitals
___ (3) Podiatrists
___ (4) Other Medical Professionals
___ (5) Clinics
___ (6) Ambulatory Surgical Centers
___ (7) Other Health Care Facilities

7. SPECIALTY CODE: 8 0 2 4 9 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (check one)
X (1) In specialty coded in Item 7, above.
___ (2) In a different specialty.
___ (3) In both the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____ (See Table C)
___ (4) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (check one)
X (1) Hospital Inpatient Facility
___ (2) Emergency Room
___ (3) Hospital Outpatient Facility
___ (4) Nursing Home
___ (5) Physician's Office
___ (6) Patient's Home
___ (7) Other Outpatient Facility
___ (8) Other Location
___ (9) Other Hospital/Institution

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: University Hospital INSTITUTION CODE: 1 9 0 0 0 1 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (check one)
X (1) Patient's Room
___ (2) Operating Suite
___ (3) Recovery Room
___ (4) Labor & Delivery Room
___ (5) Physical Therapy Dept.
___ (6) Nursery
___ (7) Critical Care Unit
___ (8) Special Procedure Room
___ (9) Radiology

13. DATE OF OCCURRENCE: 9/4/83
DATE REPORTED TO INSURER: 12/27/85

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JAN 3 1986
BUREAU OF RATES

14. INJURED PERSON'S AGE: 31 INJURED PERSON'S SEX: M E (circle one)

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15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Alleges that improper treatment was performed 17.

18. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE PROCEDURES USED. INCLUDE METHOD OF ANESTHESIA, OR NAME OF DRUG USED FOR TREATMENT, WITH DETAIL OF ADMINISTRATION: 18.

19. DESCRIBE THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE: 19.

20. SEVERITY OF INJURY: (check only one — rate most serious injury if several are involved.)

X (1) Emotional only - - - Fright, no physical damage.

Temporary	___(2)	Insignificant - - - Lacerations, contusions, minor scars, rash. No delay.
	___(3)	Minor - - - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
	___(4)	Major - - - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent	___(5)	Minor - - - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
	___(6)	Significant - - - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
	___(7)	Major - - - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
	___(8)	Grave - - - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.

___(9) Death

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21. DATE OF SUIT, IF ANY: ___/___/___

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S CODE NUMBER AND THE COMPANION CLAIM FILE IDENTIFICATION NUMBER:

DEFENDANT'S NAME (last name, first name)	INSURER CODE NO.	INSURER FILE ID.
1) M.P. Sucholeiki	509JL8700	
2)		
3)		
4)		
5)		

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (check one)
___(1) Yes X(2) No

24. DATE OF FINAL CLAIM DISPOSITION: 12/11/85

25. FINAL METHOD OF CLAIM DISPOSITION:
X(1) Settled by parties.
___(2) Disposed of by a court.
___(3) Disposed of by arbitration.

26. SETTLEMENT: (check one)
___(1) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___(2) After arbitration is initiated or prior to suit being filed.
___(3) Within 90 days of suit being filed.
___(4) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
___(5) Prior to completion of the swearing of the jury.
___(6) Prior to filing of the notice of appeal.
___(7) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___(8) During appeal.
___(9) After appeal.
X(0) Claim or suit abandoned.

27. COURT: (check one)
X(1) No court proceedings.
___(2) Directed verdict for plaintiff.
___(3) Directed verdict for defendant.
___(4) Judgment notwithstanding the verdict for the plaintiff.
___(5) Judgment notwithstanding the verdict for the defendant.
___(6) Judgment for the plaintiff.
___(7) Judgment for the defendant.
___(8) Judgment for the plaintiff after appeal.
___(9) Judgment for the defendant after appeal.
___(0) Other.

28. ARBITRATION: (check one)
X(1) Claim not subject to arbitration.
___(2) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(3) Award for plaintiff.
___(4) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (check one)
___(1) Yes X(2) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ _____ .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - $ _____ .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ _____ .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ _____ .00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - _____ days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - - - - - - - _____ days

36. INJURED PERSON'S GROSS WEEKLY INCOME: - $ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ _____ .00	$ _____ .00	$ _____ .00
B) ESTIMATED FUTURE - - - -	$ _____ .00	$ _____ .00	$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - $ _____ .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ _____ .00

B) COST TO THE INSURER OF THE PAYMENTS - $ _____ .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ _____ .00

D) DID YOU PURCHASE AN ANNUITY? ___ (1) Yes ___ (2) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: _____

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: _____

CONTACT PERSON: John Manzone ADDRESS 4040 Woodcock Drive
TELEPHONE: (904) 398-1681 Jax, Fl. 32207