FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

C1006

DEPARTMENT FILE NO. ______
INSURER'S CLAIM NO. 951-L-203789

1. PRIMARY INSURER NAME: CIGNA/INDEMNITY INS. CO. OF N.A. INSURER CODE: 01416 (See Table A)

2. EXCESS INSURER NAME: FLORIDA PATIENTS COMPENSATION FUND INSURER CODE: 46010 (See Table A)

3. INSURED'S NAME: BOYLE, JOHN J. [redacted],
(last name, first name, middle name)

STREET ADDRESS: 1216 N.W. 22ND AVE

CITY, STATE: GAINESVILLE, FLORIDA ZIP: 32601 COUNTY CODE: 11 (See Table B)

4. PRIMARY POLICY NUMBER: FML-550018 EXCESS POLICY NUMBER: -?-
PRIMARY POLICY LIMITS: $1,000,000 .00 (per claim) EXCESS POLICY LIMITS: $______ .00 (per claim)
$3,000,000 .00 (per aggregate) $______ .00 (per aggregate)

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

6. PROFESSION OR BUSINESS: (check one)
✓ (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: 80231 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

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8. BOARD CERTIFICATION: (check one)
__ (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: UNK- (See Table C)
__ (4) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (check one)
__ (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: ______ INSTITUTION CODE: ______ (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (check one)
__ (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: 4/27/84 (CLAIMS MADE POLICY)
DATE REPORTED TO INSURER: 5/1/84

14. INJURED PERSON'S AGE: 49 INJURED PERSON'S SEX: M (F) (circle one)

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(LEAVE BLANK)

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
IRREGULAR HEARTBEAT

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
NONE

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
ALLEGED IMPROPER TREATMENT UTILIZING PROCAINAMIDE

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:
DRUG INDUCED LUPUS

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:
DRUG INDUCED LUPUS

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

- ___(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: 4/25/84

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)	GARY COOPER M.D.	44050	051700
2)	FLORIDA PATIENTS COMPENSATION FUND	N/A	N/A
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 8/4/86

25. FINAL METHOD OF CLAIM DISPOSITION:
✓ (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.
___(0) Claim or suit abandoned.

27. COURT: (check one)
✓ (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)
✓ (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 ✓ (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: - - - - $ 25,000.00

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

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - - - - $ 6000 (est) .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - $ 350 .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: - - - - $ 25,000.00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - $ N/A .00

B) COST TO THE INSURER OF THE PAYMENTS - - - - $ N/A .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - $ N/A .00

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

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

N/A

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

Fully warn of drug side-effects

CONTACT PERSON: M.C. MONGELLUZZO ADDRESS P.O. BOX 30389
TELEPHONE: (813) 888-1418 TAMPA, FLORIDA 33601