01009

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. ______
INSURER'S CLAIM NO. 509ML1237-09B001

1. PRIMARY INSURER NAME: St. Paul Ins. INSURER CODE: 01470 (See Table A)
2. EXCESS INSURER NAME: Fla. Patients Comp. Fund INSURER CODE: 46010 (See Table A)
3. INSURED'S NAME: YERO, Emilio (last name, first name, middle name)

STREET ADDRESS: 1701 NE 164 St.

CITY, STATE: N. Miami Bch. Fl. ZIP: 33162 COUNTY CODE: 01 (See Table B)

4. PRIMARY POLICY NUMBER: 509ML1237 EXCESS POLICY NUMBER: 2307-11-82-82
PRIMARY POLICY LIMITS: $ 100,000 .00 (per claim) EXCESS POLICY LIMITS: $ unk .00 (per claim)
$ 300,000 .00 (per aggregate) $ unk .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: 80235 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

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: ______ (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: N/A INSTITUTION CODE: ______ (See Table B)

12. LOCATION OF INSTITUTIONAL INJURY: (check one) N/A
__ (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: 01/18/83
DATE REPORTED TO INSURER: 02/06/83

14. INJURED PERSON'S AGE: 22 INJURED PERSON'S SEX: M (F) (circle one)

DI4-303 - Amended (10-85)

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

psychiatric therapy

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

N/A

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 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.

N/A

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.

N/A

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: 06/21/83

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)	INA Health Plan	unk	unk
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 05/05/83

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: ---- $ 100,000.00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ---- $ 100,000.00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ---- $ 35749.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ---- $ 3307.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ---- 0 days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ---- 0 days

36. INJURED PERSON'S GROSS WEEKLY INCOME: ---- $ 0.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	$ 0.00	$ 0.00	$ 0.00
B) ESTIMATED FUTURE	$ 0.00	$ 0.00	$ 0.00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ---- $ 0.00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS ---- $ 0.00

B) COST TO THE INSURER OF THE PAYMENTS ---- $ 0.00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ---- $ 0.00

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:

N/A

CONTACT PERSON: Sue Slough
TELEPHONE: (305) 566-9663
ADDRESS: ST. PAUL FIRE & MARINE INS. CO.
POST OFFICE DRAWER 5807
FT. LAUDERDALE, FLORIDA 33310