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BUREAU OF RATES

FLORIDA DEPARTMENT OF INSURANCE

FLORIDA MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS REPORT

Duplicate Report attached

8700150

DEPARTMENT FILE NO. _____

INSURER'S CLAIM NO. M431-5543

1. PRIMARY INSURER NAME: INDEMNITY INS CO OF NORTH AMERICA INSURER CODE: 0141 (See Tab

2. EXCESS INSURER NAME: N/A INSURER CODE: N/A (See Tab

3. INSURED'S NAME: MIRSAJADI, AMIR A. [redacted]
(Last Name, First and Middle Name)

STREET ADDRESS: 6290 BEACH BOULEVARD

CITY, STATE: JACKSONVILLE FL ZIP: 32216 COUNTY CODE: 02 (See Table

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	FML-553371	$ 1,000,000.00	$ 3,000,000.00
EXCESS INSURER :	N/A	$ N/A	$ N/A

5. Is the insured physician a **Foreign Medical Graduate?** If yes, enter the **country** in which primary medical educ. was received: IRAN IR

- ✓ (01) Yes
- ___ (02) No

6. **PROFESSION OR BUSINESS:** (Check one)

- ✓ (01) Physicians & Surgeons
- ___ (02) Hospitals
- ___ (03) Podiatrists
- ___ (04) Other Medical Professionals
- ___ (05) Clinics
- ___ (06) Ambulatory Surgical Centers
- ___ (07) Other Health Care Faci

7. **SPECIALTY CODE:** 80249 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. **BOARD CERTIFICATION:** (Check one)

- ✓ (01) In specialty coded in Item 7, above.
- ___ (02) In a different specialty.
- ___ (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: ____ (Tabl
- ___ (04) Insured is not board certified.

9. **PLACE WHERE INJURY OCCURRED:** (Check one)

- ___ (01) Hospital Inpatient Facility
- ___ (02) Emergency Room
- ___ (03) Hospital Outpatient Facility
- ✓ (04) Nursing Home
- ✓ (05) Physician's Office
- ___ (06) Patient's Home
- ___ (07) Other Outpatient Fa i
- ___ (08) Other Location
- ___ (09) Other Hospital/Instit

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

11. NAME OF INSTITUTION: N/A INSTITUTION CODE: ____ (See Tab

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one) N/A

- ___ (01) Patient's Room
- ___ (02) Operating Suite
- ___ (03) Recovery Room
- ___ (04) Labor & Delivery Room
- ___ (05) Physical Therapy Dept.
- ___ (06) Nursery
- ___ (07) Critical Care Unit
- ___ (08) Special Procedure Roc
- ___ (09) Radiology
- ___ (10) Emergency Room

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 943-L-52435

13. **DATE OF OCCURRENCE:** 10/31/84

DATE REPORTED TO INSURER: 11/22/85

14. **INJURED PERSON'S AGE:** 37 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (M) F (Circle one)

14.1 **INJURED PERSON'S NAME:** ___

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: DEPRESSION @ SUICIDAL IDEATION — (LEAVE BLANK) 15.

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: PREMATURE PSYCHIATRIC DISCHARGE @ LETHAL DOSAGE OF SINNEQUAN — 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: N/A — 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: SUICIDE BY INGESTION OF 1.5 GRAMS OF SINNEQUAN — 19.

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

___(01) Emotional only - Fright, no physical damage.

___(02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
Temp- ___(03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
orary ___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delay
___(05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

Perma- ___(06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
nent ___(07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
___(08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
✓(09) Death

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 943-1-53435

21. **DATE OF SUIT, IF ANY:** 11/22/85

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

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID
1)	NONE		
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)
✓(01) Yes ___(02) No

24. **DATE OF FINAL CLAIM DISPOSITION:** 3/3/87

25. **FINAL METHOD OF CLAIM DISPOSITION:**
✓(01) Settled by parties.
___(02) Disposed of by a court.
___(03) Disposed of by arbitration.

26. **SETTLEMENT:** (Check one)
___(01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___(02) After arbitration is initiated or prior to suit being filed.
___(03) Within 90 days of suit being filed.
✓(04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement confe
___(05) Prior to completion of the swearing of the jury.
___(06) Prior to filing of the notice of appeal.
___(07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___(08) During appeal.
___(09) After appeal.
___(10) Claim or suit abandoned.

27. **COURT:** (Check one)
✓(01) No court proceedings.
___(02) Directed verdict for plaintiff.
___(03) Directed verdict for defendant.
___(04) Judgment notwithstanding the verdict for the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after a
___(09) Judgment for the defendant after a
___(10) Other.
___(11) Summary judgment for the plaintiff
___(12) Summary judgment for the defendant

28. **ARBITRATION:** (Check one)
✓(01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes ✓(02) No (If yes, please attach copy of settlement or verdict.)

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. H93-1524

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 165,000

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - $ NONE

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ 10,000

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 2,500

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - - N/A

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - - N/A

36. INJURED PERSON'S GROSS WEEKLY INCOME: - $ 575.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ 2654 .00	$ 67,275.00	$ .00
B) ESTIMATED FUTURE - - - -	$ — .00	$ 774,000 .00	$ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - $ comp. set of all claims for $165,00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ _____

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

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ _____

D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes ___ (02) 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: _____

A will discharge pts without lethal dosage of psychotropic medications

CONTACT PERSON: C. Mongelluzzo ADDRESS CIGNA
TELEPHONE: (813) 888-1400 PO BOX 30389
TAMPA, FL 33630-3389

DI4-303 - Amended (08-86)

F

Bill Gunter
STATE TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

State of Florida

Department of Insurance and Treasurer

THE CAPITOL
TALLAHASSEE 32399-0300

December 22, 1987

Mr. Charles Principe
CIGNA Companies
2502 Rocky Point Road
Tampa, Florida 33607

RE: 8700150 Mirsajadi, Amie A.

Dear Mr. Principe:

We have received the two enclosed reports which we believe may be for the same claim. However, the information in the following items do not agree:

7. Specialty Code
13. Date of Occurence
14. Injured Person's Age
32. LAE Paid to Defense Counsel
33. All other LAE Paid
36. Injured Person's Weekly Income
37. Injured Person's Total Economic Loss

Please confirm which information is correct.

Also, the most recent statement has "Compromise settlement of disputed claim" written across page 4 with most items left blank. This is not acceptable. Every item should be completed separately.

Our records show a doctor by the name of Abdol-Amir Mirsajadi; but, no Amir A. Mirsajadi. Please confirm whether these are the same doctor and if so let us know which name is correct.

Thank you for your cooperation.

Sincerely,

A. E. Bush
Actuarial Analyst
Bureau of Rates
904/488-4439

AEB/dm
enclosure

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

NOV 25 1987

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. H436 52435

BUREAU OF RATES

1. PRIMARY INSURER NAME: Indemnity Ins. Co. INSURER CODE: 0,1,4,1,1 (See Table A)

2. EXCESS INSURER NAME: none INSURER CODE: _____ (See Table A)

3. INSURED'S NAME: ~~Mossayebi, Cyrus A.~~
(Last Name, First and Middle Name)

STREET ADDRESS: 6290 Beach Blvd

CITY, STATE: Jax, FL ZIP: 32216 COUNTY CODE: 0,2 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	FML 553371	$ 1,000,000 .00	$ 3,000,000 .00
EXCESS INSURER :	N/A	$ N/A	$ N/A

5. Is the insured physician a **Foreign Medical Graduate?** If yes, enter the **country** in which primary medical educatio was received: Tehran, Iran
- X (01) Yes
- ___ (02) No

6. **PROFESSION OR BUSINESS:** (Check one)
- X (01) Physicians & Surgeons
- ___ (02) Hospitals
- ___ (03) Podiatrists
- ___ (04) Other Medical Professionals
- ___ (05) Clinics
- ___ (06) Ambulatory Surgical Centers
- ___ (07) Other Health Care Faciliti

7. **SPECIALTY CODE:** 8,0,2,3,5 (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)
(See Table C)

8. **BOARD CERTIFICATION:** (Check one)
- ✓ (01) In specialty coded in Item 7, above.
- ___ (02) In a different specialty.
- ___ (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____ (Table C)
- ___ (04) Insured is not board certified.

9. **PLACE WHERE INJURY OCCURRED:** (Check one)
- ___ (01) Hospital Inpatient Facility
- ___ (02) Emergency Room
- ___ (03) Hospital Outpatient Facility
- ___ (04) Nursing Home
- ___ (05) Physician's Office
- X (06) Patient's Home
- ___ (07) Other Outpatient Facility
- ___ (08) Other Location
- ___ (09) Other Hospital/Institutio

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 D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)
- ___ (01) Patient's Room
- ___ (02) Operating Suite
- ___ (03) Recovery Room
- ___ (04) Labor & Delivery Room
- ___ (05) Physical Therapy Dept.
- ___ (06) Nursery
- ___ (07) Critical Care Unit
- ___ (08) Special Procedure Room
- ___ (09) Radiology
- ___ (10) Emergency Room

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

3. **DATE OF OCCURRENCE:** 11/4/85

DATE REPORTED TO INSURER: 11/22/85

4. **INJURED PERSON'S AGE:** 44 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (M) F (Circle one)

4.1 **INJURED PERSON'S NAM**

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
recurrent major depression

(LEAVE BLANK)
15.

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

16.

7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
plaintiff given a prescription of Serequan shortly after he tried to commit suicide. 2 days later he killed himself.

17.

8. 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:
he had a history of attempted suicide using prescription antidepressant drugs.

18.

9. 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:
Plaintiff committed suicide.

19.

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

___(01) Emotional only - Fright, no physical damage.

___(02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
Temp- ___(03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
orary ___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
___(05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

Perma- ___(06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
nent ___(07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
___(08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
X (09) Death

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

21. **DATE OF SUIT, IF ANY:** 11/22/85

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

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	N/A		
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN **ATTORNEY?** (Check one)
✓ (01) Yes ___ (02) No

24. **DATE OF FINAL CLAIM DISPOSITION:** 5/6/87

25. **FINAL METHOD OF CLAIM DISPOSITION:**
X (01) Settled by parties.
___ (02) Disposed of by a court.
___ (03) Disposed of by arbitration.

26. **SETTLEMENT:** (Check one)
___ (01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___ (02) After arbitration is initiated or prior to suit being filed.
___ (03) Within 90 days of suit being filed.
X (04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference
___ (05) Prior to completion of the swearing of the jury.
___ (06) Prior to filing of the notice of appeal.
___ (07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___ (08) During appeal.
___ (09) After appeal.
___ (10) Claim or suit abandoned.

27. **COURT:** (Check one)
X (01) No court proceedings.
___ (02) Directed verdict for plaintiff.
___ (03) Directed verdict for defendant.
___ (04) Judgment notwithstanding the verdict for the plaintiff.
___ (05) Judgment notwithstanding the verdict for the defendant.
___ (06) Judgment for the plaintiff.
___ (07) Judgment for the defendant.
___ (08) Judgment for the plaintiff after appeal.
___ (09) Judgment for the defendant after appeal.
___ (10) Other.
___ (11) Summary judgment for the plaintiff.
___ (12) Summary judgment for the defendant.

28. **ARBITRATION:** (Check one)
X (01) Claim not subject to arbitration.
___ (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___ (03) Award for plaintiff.
___ (04) Award for defendant.

29. WAS THERE AN ITEMIZED **VERDICT** UNDER FLORIDA STATUTE 768.48? (Check one)
___ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIARILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 165,000 .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - - $ N/A .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:* - - - - - - - - - - - - - - - - - _____ da

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

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**? ___ (01) Yes ✓ (02) 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: _____

CONTACT PERSON: Charles Principe ADDRESS 2507 Rocky Pt Dr.
TELEPHONE: (813) 888-1428 Tampa, FL 33630

DI4-303 - Amended (08-86)