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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 8700687
INSURER'S CLAIM NO. 86-8014-0001

1. PRIMARY INSURER NAME: Physicians Protective Trust Fund INSURER CODE: 44050 (See Table A)
2. EXCESS INSURER NAME: N/A INSURER CODE: N/A (See Table A)
3. INSURED'S NAME: Simon Juan A. (Last Name, First and Middle Name)
   STREET ADDRESS: 11880 S.W. 40th Street
   CITY, STATE: Miami, Florida ZIP: 33175 COUNTY CODE: 011 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	0258000	$ 500,000 .00	$ 500,000 .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 education was received:
   ___ (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 Facilities

7. SPECIALTY CODE: 801208 (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: N/A (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
   ___ (06) Patient's Home
   ___ (07) Other Outpatient Facility
   ___ (08) Other Location
   ___ (09) 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: Larkin Hospital INSTITUTION CODE: 100184 (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

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INSURER'S CLAIM NO. 86-3014-02-001

3. DATE OF OCCURRENCE: 12/21/82

DATE REPORTED TO INSURER: 06/02/86

4. INJURED PERSON'S AGE: 55 Years (If less than one year, then enter 01)

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

4.1 INJURED PERSON'S NAME: ___ _____ _____ _____
Last Name First and Middle Initial

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

labial herpes and facial drooping on the left side - Bells Palsey — 15.

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

Failure to diagnose brain tumor (meningioma

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

Patient had a brain tumor excised, two years after he was diagnosed as having Bells Palsey.

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: 18.

Dr Simon never saw patient

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: 19.

Patient alleges that he has had pain and disability as well as expence and wage loss because his brain tumor was not found two years earlier; failure to follow up, failure to treat, failure to diagnose

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.
___(09) Death

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INSURER'S CLAIM NO. 96-8014-02-001

21. **DATE OF SUIT, IF ANY:** 08/30/95

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)		
2)		
3)		
4)		
5)		

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

24. **DATE OF FINAL CLAIM DISPOSITION:** 02/20/97

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 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)
✓(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)
✓(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.)

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INSURER'S CLAIM NO. 86801402001

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 0 .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - - $ 0 .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ 753 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 984 .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: - $ .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: - $ 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? ___ (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: N/A

CONTACT PERSON: Robert E White Jr ADDRESS P.O. Box 149001
TELEPHONE: (305) 442-4001 Coral Gables, Florida 33114