

FLORIDA DEPARTMENT OF INSURANCE
 FLORIDA MEDICAL PROFESSIONAL LIABILITY
 CLOSED CLAIM REPORTING FORM

8803666

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 0509 ML 1238 09B300

PRIMARY INSURER NAME: Florida Medical Malpractice JWA INSURER CODE: 46030
 (See Table A)

EXCESS INSURER NAME: none INSURER CODE: |||||
 (See Table A)

HEALTH CARE PROVIDER: VILLALBA, Benjamin R.
 (Last Name, First and Middle Name or Hospital Name from Table D)

IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
 PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0033974

INSURED'S NAME: Benjamin Villalba Same

STREET ADDRESS: 3661 S. Miami Ave

CITY: Miami STATE: Fl ZIP: 33169 COUNTY CODE: 01
 (See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>509ML1238</u>	<u>\$ 100,000.00</u>	<u>\$ 300,000.00</u>
EXCESS INSURER:	<u> </u>	<u>\$.00</u>	<u>\$.00</u>

IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? (01) Yes (02) No (If yes, enter the country
 in which primary medical education was received: Cuba)

6. PROFESSION OR BUSINESS: (Check one)
- | | | |
|--|---|---|
| <input checked="" type="checkbox"/> (01) Physicians & Surgeons | <input type="checkbox"/> (04) Dentist | <input type="checkbox"/> (07) Crisis Stabilization Unit |
| <input type="checkbox"/> (02) Hospitals | <input type="checkbox"/> (05) Abortion Clinics | <input type="checkbox"/> (08) Health Maintenance Organization |
| <input type="checkbox"/> (03) Podiatrists | <input type="checkbox"/> (06) Ambulatory Surgical Centers | |

7. SPECIALTY CODE: 80241 (Applies to physicians, surgeons, and dentists.
 (See Table C) 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. Enter the additional specialty code here: _____
 - (04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> (01) Hospital Inpatient Facility | <input type="checkbox"/> (04) Nursing Home | <input type="checkbox"/> (07) Other Outpatient Facility |
| <input type="checkbox"/> (02) Emergency Room | <input type="checkbox"/> (05) Physician's Office | <input type="checkbox"/> (08) Other Location |
| <input type="checkbox"/> (03) Hospital Outpatient Facility | <input type="checkbox"/> (06) Patient's Home | <input type="checkbox"/> (09) Other Hospital/Institution |

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: Mount Sinai Medical Center of Miami INSTITUTION CODE: 100034
 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

<input checked="" type="checkbox"/> (01) Patient's Room	<input type="checkbox"/> (05) Physical Therapy Dept.	<input type="checkbox"/> (09) Radiology
<input type="checkbox"/> (02) Operating Suite	<input type="checkbox"/> (06) Nursery	<input type="checkbox"/> (10) Emergency Room
<input type="checkbox"/> (03) Recovery Room	<input type="checkbox"/> (07) Critical Care Unit	<input type="checkbox"/> (11) Other _____
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	_____

13. DATE OF OCCURRENCE: 00/19/80
 DATE REPORTED TO INSURER: 02/19/89

14. INJURED PERSON'S AGE: 49 Years (If less than one year, enter 00; if unknown, enter UNK.)
 INJURED PERSON'S SEX: M F (Circle one)

14.1 INJURED PERSON'S NAME: J
 STREET ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Gastric pain, hiatal hernia, ulcers (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: alleged insured did not offer "surgery" to patient
 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: only warned patient call for consult.
 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: patient has continued stomach problems, also has had surgeries
 19.

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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 dela
- (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

21. DATE OF SUIT, IF ANY: 9/15/85

21.1 CIRCUIT COURT CASE NUMBER: 85-40728

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 11 (SEE TABLE B)

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)	<u>20 co-def unable to name</u>		
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 09/19/88

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

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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 filed and prior to or during the course of mandatory settlement conferenc
- (05) During trial but before court verdict.
- (06) After court verdict and prior to filing of notice of appeal.
- (07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claim or suit abandoned.

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27. COURT: (Check one)
- (01) No court proceedings.
 - (02) Directed verdict for plaintiff.
 - (03) Directed verdict for defendant.
 - (04) Judgment notwithstanding the verdict for plaintiff.
 - (05) Judgment notwithstanding the verdict for 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 settlement reached in lieu of award.
 - (03) Award for plaintiff.
 - (04) Award for defendant.

29. Was there an itemized verdict? (Check one)
 (01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 9000.00

30.1 AMOUNT OF DEDUCTIBLE PAID BY 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: ----- \$ 5100.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 6300.00

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:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 9000.00

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

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

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one)

(01) No limit (neither party requests or agrees to voluntary binding arbitration).
 (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
 (03) \$250,000 limit (both parties accept arbitration). (See Item 42 for exception.)
 (04) \$350,000 limit (plaintiff rejects arbitration).
 (05) Does not apply because occurrence happened before the 02-08-88 law.

42. IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMIC DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: ----- \$ N/A .00

43. COLLATERAL SOURCE INFORMATION:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM: unknown

A. <input type="checkbox"/> % Health	D. <input type="checkbox"/> % Automobile
B. <input type="checkbox"/> % Disability	E. <input type="checkbox"/> % Medicare, Medicaid & Social Security
C. <input type="checkbox"/> % Workers' Compensation	F. <input type="checkbox"/> % Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: None taken - saw no risk factors

CONTACT PERSON: Carol L. Howell
TELEPHONE: (325) 485-2520

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