RECEIVED

JUN 1989

BUREAU OF RATES

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

8900202
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: DM00900150-09C002

1. PRIMARY INSURER NAME: ST PAUL F+M INSURER CODE: 0147D (See Table A)

2. EXCESS INSURER NAME: NA INSURER CODE: _____ (See Table A)

3a. HEALTH CARE PROVIDER: Elstein, William NMI
(Last Name, First and Middle Name or Hospital Name from Table D)

3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0026682

3c. INSURED'S NAME: SAME

STREET ADDRESS: 3920 Bee Ridge Road

CITY: Sarasota STATE: FL ZIP: 34232 COUNTY CODE: 16 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	DM00900150	$ 500,000.00	$ 1,500,000.00
EXCESS INSURER:	NA	$ 0 .00	$ 0 .00

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

6. PROFESSION OR BUSINESS: (Check one)
- ✓ (01) Physicians & Surgeons
- ___ (02) Hospitals
- ___ (03) Podiatrists
- ___ (04) Dentist
- ___ (05) Abortion Clinics
- ___ (06) Ambulatory Surgical Centers
- ___ (07) Crisis Stabilization Unit
- ___ (08) Health Maintenance Organization

7. SPECIALTY CODE: 80256 (See Table C) (Applies to physicians, surgeons, and dentists. 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: _____ (See 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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: NA

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

11. NAME OF INSTITUTION: NA INSTITUTION CODE: _____ (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

NA
- ___ (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
- ___ (11) Other _____

13. DATE OF OCCURRENCE: 05/05/88

DATE REPORTED TO INSURER: 05/27/88

14. INJURED PERSON'S AGE: 82 Years (If less than one year, enter 00; if unknown, enter UNK.)

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

14.1 INJURED PE

STRE

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Removal of Skin Cancer Spots left hand, left cheek & left chest. 15.

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
AFTER PROCEDURE PATIENT STOOD UP & FELL TO FLOOR. 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:
Squamous Cell Carcinoma left hand & left cheek & BASAL cell carcinoma chest 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:
patent stood up & Fell breaking his glasses & LACERATING his forehead. 19.

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

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

21. DATE OF SUIT, IF ANY: NA

21.1 CIRCUIT COURT CASE NUMBER: NA

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: N.A (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)			
2)	NONE		
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 01/10/89

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 conference
___(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.

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

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: - $ 9,500.00

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: - $ 0.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 80.00

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? ___ (01) Yes ✓ (02) No

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

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

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: - $ 0 .00

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

A. ___% Health NA
B. ___% Disability
C. ___% Workers' Compensation
D. ___% Automobile
E. ___% Medicare, Medicaid & Social Security
F. ___% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: None Recommended

CONTACT PERSON: Cindy Harris ADDRESS P.O. Box 31826
TELEPHONE: (813) 286-1154 Tampa, FL. 33631-3826