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

9300131

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 90-14207-01-034

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: |4|4|0|5|0|

2. EXCESS INSURER NAME: N/A INSURER CODE: |N/A| | | | |

3a. HEALTH CARE PROVIDER: Andriola, Michael John
(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 OR PROFESSIONAL REGULATION LICENSE NUMBER: |0|0|1|2|5|0|3|

3c. INSURED'S NAME: Michael J. Andriola, M.D.

STREET ADDRESS: 1011 Jeffords Street

CITY: Clearwater STATE: |F|L| ZIP: |3|4|6|1|6| COUNTY CODE: |0|4|
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	M-1005702	$ 1,000,000 .00	$ 3,000,000 .00
EXCESS INSURER:	N/A	$ N/A .00	$ N/A .00

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

6. PROFESSION OR BUSINESS: (Check One)

X	(01) Physicians & Surgeons	___	(04) Dentist	___	(07) Crisis Stabilization Unit
___	(02) Hospitals	___	(05) Abortion Clinics	___	(08) Health Maintenance
___	(03) Podiatrists	___	(06) Ambulatory Surgical Centers		

7. SPECIALITY CODE: |8|0|2|6|1| (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check One)

X	(01)	In speciality code 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.	

PLACE WHERE INJURY OCCURRED: (Check One)

X	(01) Hospital Inpatient Facility	___	(04) Nursing Home	___	(07) Other Outpatient Facility
___	(02) Emergency Room	___	(05) Physician's Office	___	(08) Other Location
___	(03) Hospital Outpatient Facility	___	(06) Patient's Home	___	(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: Morton F. Plant Hospital INSTITUTION CODE |1|0|0|1|2|7| (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

X	(01)	Patient's Room	___	(05)	Physical Therapy Dept.	___	(09)	Radiology
___	(02)	Operating Room	___	(06)	Nursery	___	(10)	Emergency Room
___	(03)	Recovery Room	___	(07)	Critical Care Unit	___	(11)	Other: _____
___	(04)	Labor & Delivery Room	___	(08)	Special Procedure Room			

13. DATE OF OCCURRENCE: 06|28|88

DATE REPORTED TO INSURER: 07|02|90

14. INJURED PERSON'S AGE: 69 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:

STREET ADDRESS:

CITY:

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

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.
Patient got out of bed and fell.

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.
Not applicable. Treatment did not cause injury.

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.
Fractured mandible.

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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, missed fracture, fall in hospital. Recovery delayed.
orary	___	(04)	Major- - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
	X	(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- - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
	___	(09)	Death

21. DATE OF SUIT, IF ANY: 10 | 03 | 90

21.1 CIRCUIT COURT CASE NUMBER: 90-016564-009

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 10 | 4 | (SEE TABLE B)

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE TO 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)
X (01) Yes ____ (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 12 | 31 | 92

25. FINAL METHOD OF CLAIM DISPOSITION:
X (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.
X (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 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.

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27. COURT: (Check One)

X	(01) No court proceedings.	___	(07) Judgement for the defendant.
___	(02) Directed verdict for plaintiff.	___	(08) Judgement for the plaintiff after appeal.
___	(03) Directed verdict for defendant.	___	(09) Judgement for the defendant after appeal.
___	(04) Judgment notwithstanding the verdict for plaintiff.	___	(10) Other Settled by parties.
___	(05) Judgment notwithstanding the verdict for defendant.	___	(11) Summary Judgement for the plaintiff.
___	(06) Judgment for the plaintiff.	___	(12) Summary Judgement for the defendant.

28. ARBITRATION: (Check One)

X	(01) Claim not subject to arbitration.	___	(03) Award for plaintiff.
___	(02) Claim subject to arbitration, but settlement reached in lieu of award.	___	(04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT? (Check One)

____ (01) Yes X (02) No (If yes, please attach copy of settlement verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ..... $ 7,500.00

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: ..... $ 21,566.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ..... $ 15,390.00

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 X (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) N/A

___ (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-ECONOMICAL DAMAGES IS DIFFERENT THAN $250,000, THEN INDICATE THE MODIFIED LIMIT: ..... $ 0 .00

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

A.	0%	Health	D.	0%	Automobile
B.	0%	Disability	E.	0%	Medicare, Medicaid & Social Security
C.	0%	Worker's Compensation	F.	0%	Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURER TO MAKE SIMILAR OCCURRENCE LESS LIKELY: N/A

CONTACT PERSON: Catherine Burney
TELEPHONE: 813/933-8517

ADDRESS: Physicians Protective Trust Fund
2901 W. Busch Blvd, Suite 503
Tampa, Florida 33618