

RECEIVED

NOV 8 1993

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

9302038

DEPT. FILE NO.

BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 1107

1. PRIMARY INSURER NAME: Frontier Insurance Company INSURER CODE: 0,9,5,7,4
(See Table A)

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

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

RECEIVED
DEC 10 1993

3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 2,0,4,4,4,0,2

3c. INSURED'S NAME: Guillermo Blanco, M.D. BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

STREET ADDRESS: 1559 Northwest 164th Street

CITY: North Miami Beach STATE: FL ZIP: 3,3,1,6,2 COUNTY CODE: 0,1,1
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>201709</u>	<u>\$ 250,000 .00</u>	<u>\$ 750,000 .00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ N/A .00</u>	<u>\$ N/A .00</u>

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: Columbia, South America CO)

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

7. SPECIALTY CODE: 8,0,2,6,1 (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)
 (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

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

11. NAME OF INSTITUTION: North Shore Medical Center INSTITUTION CODE: 1,0,0,0,2,9
 (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 checked="" 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: 10/08/89
 DATE REPORTED TO INSURER: 09/28/90

14. INJURED PERSON'S AGE: 44 Years (If less than one year, enter 00; if unknown, enter UNK.)
 INJURED PERSON'S SEX: M (Circle one)

14.1 INJURED PERSON'S NAME: _____
 STREET ADDRESS: _____
 CITY: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK)
<u>Dizziness, weakness, light-headed, weakness in right side of body</u>	15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:	16.
<u>Failure to evaluate syncopal episode</u>	
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:	17.
<u>Resulted in stroke</u>	
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.
<u>Failure to evaluate syncopal episode resulted in stroke which resulted in complete incapacitation</u>	
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.
<u>Stroke</u>	

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 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

21. DATE OF SUIT, IF ANY: 05/09/91

21.1 CIRCUIT COURT CASE NUMBER: 91-09376 CA 02

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 011 (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>Jacobsen, Rodney</u>	_____	_____
2) <u>Vicaria, Carlos</u>	_____	_____
3) <u>Campbell, William</u>	_____	_____
4) <u>Iglesia, Roberto</u>	_____	_____
5) <u>Parker, James</u>	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 10/24/93

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)
- | | |
|---|--|
| <input checked="" type="checkbox"/> (01) No court proceedings. | <input type="checkbox"/> (07) Judgment for the defendant. |
| <input type="checkbox"/> (02) Directed verdict for plaintiff. | <input type="checkbox"/> (08) Judgment for the plaintiff after appeal. |
| <input type="checkbox"/> (03) Directed verdict for defendant. | <input type="checkbox"/> (09) Judgment for the defendant after appeal. |
| <input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff. | <input type="checkbox"/> (10) Other |
| <input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant. | <input type="checkbox"/> (11) Summary judgment for the plaintiff. |
| <input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (12) Summary judgment for the defendant. |

28. ARBITRATION: (Check one)
- | | |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration. | <input type="checkbox"/> (03) Award for plaintiff. |
| <input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (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: ----- \$ 230,000.00

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: ----- \$ 42,735.84.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 33,394.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- unk days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- unk days

36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ unk.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ N/A.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM: N/A
- | | |
|--|--------------|
| 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? <input type="checkbox"/> (01) Yes <input type="checkbox"/> (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: 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:

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

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

CONTACT PERSON: Beverly McIntosh ADDRESS: 195 LAKE LOUISE MARIE Rd
TELEPHONE: (914) 796-2300 x267 ROCK Hill, NY 12775