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RELEASE

FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

9400182

DEPT. FILE NO.

JAN 10 1994

BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 2463

1. PRIMARY INSURER NAME: Frontier Insurance Company INSURER CODE: 09574
(See Table A)

2. EXCESS INSURER NAME: Unknown INSURER CODE: unk
(See Table A)

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

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3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 01037230 FEB 2 1994

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

STREET ADDRESS: 2041 Hawaii Avenue N.E.

CITY: St. Petersburg STATE: FL ZIP: 33703 COUNTY CODE: 04
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>ERM0001629</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
EXCESS INSURER:	<u>unk</u>	<u>\$ unk.00</u>	<u>\$ unk.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: N/A)

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

7. SPECIALTY CODE: 8,0,2,4,4 (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: n/a
 (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 MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

11. NAME OF INSTITUTION: n/a INSTITUTION CODE: n/a (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

<input 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 <u>n/a</u>
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 02/11/92

DATE REPORTED TO INSURER: 06/29/93

14. INJURED PERSON'S AGE: 40 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: H (Circle one)

14.1 INJURED PERSON'S NAME:

STREET ADDRESS:

CITY:

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Breast cancer (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: Failure to diagnose breast cancer on mammogram. 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Failure to timely diagnose breast cancer in a 40 year old female, mother of 3. Our insured misread mammogram. 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: On two separate occasions a mammogram was done - no masses were detected 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: Breast cancer 19.

FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

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

11. DATE OF SUIT, IF ANY: n/a

11.1 CIRCUIT COURT CASE NUMBER: n/a

11.2 COUNTY CODE OF COUNTY SUIT FILED IN: n/a (SEE TABLE B)

12. 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)	<u> n/a </u>	<u> n/a </u>	<u> n/a </u>
4)	_____	_____	_____
5)	_____	_____	_____

13. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)

- (01) Yes
- (02) No

14. DATE OF FINAL CLAIM DISPOSITION: 12/30/93

15. FINAL METHOD OF CLAIM DISPOSITION:

- (01) Settled by parties.
- (02) Disposed of by a court.
- (03) Disposed of by arbitration.

16. 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 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: ----- \$ \$ 575,000.00

30.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: ----- \$ 00.00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 00.00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 3,469.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 2,390.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- 00 days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- 00 days

36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ 00.00

37. INJURED PERSON'S

TOTAL ECONOMIC LOSS:	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - -	\$ <u>00.00</u>	\$ <u>00.00</u>	\$ <u>00.00</u>
B) ESTIMATED FUTURE - - - -	\$ <u>00.00</u>	\$ <u>00.00</u>	\$ <u>00.00</u>

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 00.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

- | | |
|---|-----------------|
| A) PRESENT VALUE OF PERIODIC PAYMENTS ----- | \$ <u>00.00</u> |
| B) COST TO THE INSURER OF THE PAYMENTS ----- | \$ <u>00.00</u> |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- | \$ <u>00.00</u> |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" type="checkbox"/> (02) No | |

FLORIDA MEDICAL PROFESSIONAL LIABILITY
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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: ----- \$ 00.00

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: Attend Risk Management Seminars

CONTACT PERSON: Patricia E. Schmidt ADDRESS 195 Lake Louise Marie Road
TELEPHONE: PH 5796-2300 Ext 375 Rock Hill, N.Y. 12775-8000

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APR 20 1994

RELEASE AND SETTLEMENT AGREEMENT

RATES P/C
OF INSURANCE

KNOW ALL MEN BY THESE PRESENTS, that I, and in consideration of the sum of FIVE HUNDRED SEVENTY-FIVE THOUSAND DOLLARS, (\$575,000), receipt of which is hereby acknowledged, do hereby forever release and discharge Charles Hirt, M.D., Frontier Insurance Company, and any other persons, firms, *ms* corporations, partnerships and insurers charged or chargeable with responsibility or liability for their conduct, and all of their respective heirs, agents, servants, employees, representatives, successors and assigns, hereinafter referred to as RELEASEES, of and from any and all claims, demands, damages, actions, causes of action, on account of any and all personal injury, death, disability, property damage, loss or damage of any kind whatsoever, known or unknown, sustained heretofore or hereafter in consequence of any medical treatment rendered by RELEASEES or any other incidents, casualties, events, acts, or omissions from the beginning of time down to the date hereof.

In making this Release and Settlement Agreement, I hereby declare and represent that I am more than eighteen (18) years of age; that I am duly authorized and empowered to make this Release and Settlement Agreement; that I have never been declared incompetent by any court or administrative agency; that no representations respecting the nature and extent of any injuries, disabilities, damages, legal liability or financial responsibility made by any physician, agent or employee of RELEASEES have induced me to make this settlement; that in determining the sum I have accepted in consideration hereof, there has been taken into account not only the ascertained injuries, disabilities, losses and damages, but also unknown and/or unanticipated injuries, disabilities, losses and damages to which I recognize and agree this settlement shall also apply.

It is understood that the parties hereby released admit no liability of any sort by reason of the aforesaid incidents, acts, casualties or events. It is further recognized and understood that this Release and Settlement Agreement constitutes the good faith compromise of a doubtful and disputed claim, and is made in good faith to terminate any further controversy respecting all claims for damages that I may have heretofore asserted or might hereafter assert because of any medical treatment incidents, acts, casualties, or events, described or alluded to hereinabove.

As further consideration for the aforesaid payment and settlement, I do hereby covenant and agree with RELEASEES that:

1. This Release and Settlement Agreement may be pleaded as a defense to any action or other proceeding which may be brought or instituted against them in breach hereof.

2. That I will hold RELEASEES harmless and indemnify them from and for any and all liens asserted by anyone or any entity against this settlement, and that I will indemnify and satisfy from

the monies hereby received any person, corporation, or agency of government asserting a lien against this settlement, and that I will secure releases on behalf of RELEASEES from any such persons asserting a lien of whatsoever nature.

3. That I will hold harmless and indemnify RELEASEES from and for any and all actions, causes of action, damages and costs, including reasonable attorney's fees, incurred in defense of or in settlement of all actions, causes of action, suit or suits, or demands, third party or otherwise, which may be brought or made against said RELEASEES arising out of the matters discharged and released hereby, except for claims of any kind between the RELEASEES.

As further consideration for this Release and Settlement Agreement, and in recognition that the purpose hereof is to lay to rest further litigation, controversy, and public comment respecting disputes between the parties, and to permit RELEASEES to buy their peace, I hereby covenant, promise, agree and stipulate, that the existence of, terms, conditions, and amount of this Release and Settlement Agreement cannot and will not be disclosed by either myself or my attorneys to any person or persons whomsoever, expressly including, but in no way limited to, members of the press or elements of the news media. I specifically covenant, recognize and agree that breach hereof by disclosure to any person or persons, including but not limited to the news media, is prohibited by this Release and Settlement Agreement, that irreparable harm would be caused RELEASEES by its breach, and that breach of this condition may be enforced by appropriate civil action to enjoin further violation, or to recover such other damages as may have been caused by such breach.

SIGNED AND DATED this 28th day of December, 1993, in Pasco County, Florida.

WITNESSES:

STATE OF FLORIDA)
COUNTY OF PASCO)

The foregoing instrument was acknowledged before me this December 28, 1993, by Martha Sandifer, who is,

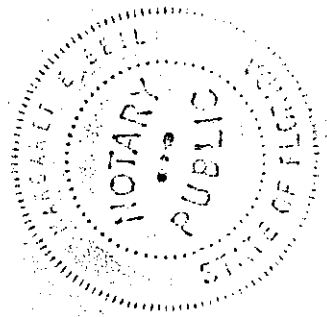
personally known to me or who has produced _____,
as identification and who did (did not) take an oath.

Margaret E. Bell
Name: MARGARET E. BELL
Notary Public of the State of
Florida
Serial Number: CC088376

My Commission expires on:

doc.136792

**NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXP. MAR. 4, 1995
BONDED THRU GENERAL INS. UND.**



SEE RIDER "A" WHICH IS ATTACHED HERETO AND INCORPORATED
BY ITS TERMS INTO THIS RELEASE.

RIDER "A"

THE RELEASOR(S) further state that while he hereby releases all claims against Releasee(s), their agents and employees, the payment hereunder does not satisfy all of his damages resulting from the accident, including but not limited to, past and future medical and health care expenses which may have been incurred or may be incurred in the future and which is not being paid in this settlement. The Releasor(s) further reserve their right to pursue and recover all unpaid damages from any person, firm or organization who may be responsible for payment of such damages, including any first party health or automobile insurance coverage, but such reservation does not include the Releasee(s), its/their agents or employees.