

RECEIVED

FEB 11 1994

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

9400200

DEPT. FILE NO.

BUREAU OF RATES P/C  
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 92-16940-029

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 44050  
(See Table A)

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

3a. HEALTH CARE PROVIDER: Cornelio, Rafael Elias  
(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: ~~12345~~ 010295411

3c. INSURED'S NAME: Same as 3a.

STREET ADDRESS: 900 N.W. 13 Street, Suite #105

CITY: Boca Raton STATE: FL ZIP: 33486 COUNTY CODE: 06  
(See Table B)

| 4.               | POLICY NUMBER    | PER CLAIM POLICY LIMITS | AGGREGATE POLICY LIMITS |
|------------------|------------------|-------------------------|-------------------------|
| PRIMARY INSURER: | <u>M-1006095</u> | \$ <u>250,000.00</u>    | \$ <u>750,000.00</u>    |
| EXCESS INSURER:  | <u>N/A</u>       | \$ <u>0.00</u>          | \$ <u>0.00</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: Dominican Republic DR

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: 80249 (Applies to physicians, surgeons, and dentists.  
Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check One)

- (01) In specialty 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: \_\_\_\_\_  
 (04) Insured is not Board Certified. (see table C)

9. PLACE WHERE INJURY OCCURRED: (Check One)

- |  |   |  |
|--|---|--|
| <input 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 checked="" 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





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

27. COURT: (Check One)

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

28. ARBITRATION: (Check One)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.<br><input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.<br><input type="checkbox"/> (04) Award for defendant. |
|--|--|

29. Was there an itemized verdict? (Check One)

- (01) Yes     (02) No

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . \$ 0.00

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: . . . . . \$ 3,505.00

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<br>TOTAL ECONOMIC LOSS: | MEDICAL        | WAGE LOSS      | OTHER EXPENSES |
|--|----------------|----------------|----------------|
| A) INCURRED TO DATE . . .                    | \$ <u>0.00</u> | \$ <u>0.00</u> | \$ <u>0.00</u> |
| B) ESTIMATED FUTURE . . .                    | \$ <u>0.00</u> | \$ <u>0.00</u> | \$ <u>0.00</u> |

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 . . . . .   | \$ <u>0.00</u> |
| B) COST TO THE INSURER OF THE PAYMENTS . . . . .  | \$ <u>0.00</u> |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF . . . . .  | \$ <u>0.00</u> |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" 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-ECONOMICAL DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: . . . . . \$ N/A

43. COLLATERAL SOURCE INFORMATION:

ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

- |                                     |  |
|-------------------------------------|--|
| A. <u>0</u> % Health                | D. <u>0</u> % Automobile                           |
| B. <u>0</u> % Disability            | E. <u>0</u> % Medicare, Medicaid & Social Security |
| C. <u>0</u> % Worker's Compensation | F. <u>0</u> % Other sources, specify: _____        |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURE TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Member discussed case with insurance company.  
\_\_\_\_\_  
\_\_\_\_\_

CONTACT PERSON: David J. Forestner, Ft. Laud. Reg. Claims Mgr.  ADDRESS: Physicians Protective Trust Fund  
6365 NW 6 Way, Suite 220  
TELEPHONE: (305) 491-5667 Fort Lauderdale, Florida 33309