

DEC 8 1995

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

9502552

DEPT. FILE NO.

BUREAU OF PROPERTY &  
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 95MO4509

1. PRIMARY INSURER NAME: FRONTIER INSURANCE CO OF NEW YORK INSURER CODE: 09574

(See Table A)

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

(See Table A)

3a. HEALTH CARE PROVIDER: KURLANDER, RONALD HOWARD  
(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: 0033297

3c. INSURED'S NAME: Ronald Kurlander, MD

STREET ADDRESS: 1 West Sample Road, Suite 205

CITY: Pompano Beach STATE: FL ZIP: 32064 COUNTY CODE: 10  
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>CM0502485-4</u>	<u>\$ 1,000,000 .00</u>	<u>\$ 3,000,000 .00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ .00</u>	<u>\$ .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: Mexico **MX**)

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: 80249 (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: \_\_\_\_\_

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NAME OF INSTITUTION: Imperial Point Medical Center INSTITUTION CODE: 16,020,0  
 (See Table D)

2. 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 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 |  |

3. DATE OF OCCURRENCE: 06/26/92  
 DATE REPORTED TO INSURER: 07/28/95

4. INJURED PERSON'S AGE: 48 Years (If less than one year, enter 00; if unknown, enter UNK.)  
 INJURED PERSON'S SEX: M  F (Circle one)

4.1 INJURED PERSON'S NAME:  
 STREET ADDRESS:  
 CITY:

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: MANIC Depression (LEAVE BLANK)  
 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: N/A  
 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: The patient was voluntarily admitted to the psych unit with a history of manic depression. She was treated and released right after later in stable condition to be followed by her physicians in Ohio. The allegation of violation of civil rights was not substantiated.  
 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: N/A  
 18. voluntarily dismissed.

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: NONE  
 19.

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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, 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: 07/28/95

21.1 CIRCUIT COURT CASE NUMBER: 95-6661

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 10 (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>Imperial Point Medical Center</u>	<u>46213</u>	
2)	<u>A. Gary Muller</u>	<u>46213</u>	
3)			
4)			
5)			

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

- (01) Yes
- (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 11/27/95

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.

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17. COURT: (Check one)
- |   |  |
|---|--|
| <input 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 checked="" 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.      |

18. 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: ----- \$ 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: ----- \$ 3925.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 1135.00

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:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
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 |                |

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0. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

1. 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.

2. 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

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

A. <input type="checkbox"/> % Health	D. <input type="checkbox"/> % Automobile
B. <input type="checkbox"/> % Disability	E. <input type="checkbox"/> % Medicare, Medicaid & Social Security
C. <input type="checkbox"/> % Workers' Compensation	F. <input type="checkbox"/> % Other sources, specify: _____

4. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:  
Insured has discussed case with insurance personnel and defense counsel.

CONTACT PERSON: CARDLANN LOBACZ ADDRESS 6360 NW 5th WAY SUITE 303  
TELEPHONE: (800) 708-4018 x107 FORT LAUDERDALE, FL 33304