MAY 21 1996

BUREAU OF PROPERTY & CASUALTY FORMS & RATES

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

9601310
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: A95-16328-93

1. PRIMARY INSURER NAME: Florida Physicians Insurance Company INSURER CODE: 0,9,5,8,3 (See Table A)

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

3a. HEALTH CARE PROVIDER: SABLE, STEVEN G.
(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: 0,0,0,5,8,3,4

3c. INSURED'S NAME: SAME

STREET ADDRESS: 615 EAST PRINCETON ST. SUITE 500

CITY: ORLANDO STATE: FL ZIP: 3,2,8,0,3 COUNTY CODE: 0,7 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	9706	$ 500,000.00	$ 1,500,000.00
EXCESS INSURER:	N/A	$ .00	$ .00

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: _____

6. PROFESSION OR BUSINESS: (Check one)

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

7. SPECIALTY CODE: 8,4,2,6,1 (See Table C) (Applies to physicians, surgeons, and dentists. 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: _____ (See Table C)
___ (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check one)

✓ (01) Hospital Inpatient Facility
___ (02) Emergency Room
___ (03) Hospital Outpatient Facility
___ (04) Nursing Home
___ (05) Physician's Office
___ (06) Patient's Home
___ (07) Other Outpatient Facility
___ (08) Other Location
___ (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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11. NAME OF INSTITUTION: HUMANA HOSPITAL LUCERNE INSTITUTION CODE: 1,0,0,2,2,1
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

___ (01) Patient's Room	___ (05) Physical Therapy Dept.	___ (09) Radiology
___ (02) Operating Suite	___ (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: 02/23/93

DATE REPORTED TO INSURER: 03/10/95

14. INJURED PERSON'S AGE: 52 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)

OBESITY — 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:

DEATH OF PATIENT — 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:

GASTRIC BYPASS SURGERY — 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:

DEATH FROM POSTOPERATIVE COMPLICATIONS — 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.

Temporary
___(02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
___(03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed

Permanent
___(05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
___(06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
___(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: 06/14/95

21.1 CIRCUIT COURT CASE NUMBER: CI 95-610/DIV 32

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 07 (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)	MICHAEL BUTLER, MD	NOT KNOWN	NOT KNOWN
2)	MARIA LAGADE, MD	" "	" "
3)	DONALD ELTON, MD	09583	B95-16328-93
4)	HUMANA HOSPITAL LUCERN	NOT KNOWN	NOT KNOWN
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 03/22/96

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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27. COURT: (Check one)

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

28. ARBITRATION: (Check one)

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

29. Was there an itemized verdict? (Check one) N/A
___(01) Yes ___(02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ Ø .00

30.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: - $ — 0 — .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - $ N/A .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ 23,741 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 8,444 .00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - NOT KNOWN days

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

36. INJURED PERSON'S GROSS WEEKLY INCOME: - $ @84 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ NOT KNOWN .00	$ NOT KNOWN .00	$ NOT KNOWN .00
B) ESTIMATED FUTURE - - - -	$ N/A .00	$ " " .00	$ " " .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: 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? ___ (01) Yes ___ (02) No

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: NA

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

43. COLLATERAL SOURCE INFORMATION: NOT KNOWN
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: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:
NOT ACTION NECESSARY

ED HAYES

CONTACT PERSON: _____ ADDRESS 1000 Riverside Avenue, P.O. Box 44033
TELEPHONE: (904) 354-5910 Jacksonville, Florida 32231-4033