JUN 18 1996

BUREAU OF PROPERTY & CASUALTY FORMS & RATES

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

9601467
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 94-21694-00-041

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: | 4 | 4 | 0 | 5 | C (See Table A)

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

3a. HEALTH CARE PROVIDER: ANAYAS, MARCELO RAMOS
(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|4|8|7|2|0|

3c. INSURED'S NAME: MARCELO R ANAYAS, M.D.

STREET ADDRESS: 80 HIGHWAY 17 92

CITY: DEBARY STATE: | F | L | ZIP: | 3 | 2 | 7 | 1 | 3 | COUNTY CODE: | 0 | 8 | (See Table

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	1002868	$ 250,000.00	$ 750,000.00
EXCESS INSURER:	N/A	$ 0.00	$ 0.00

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? X (01) Yes ___ (02) No (If yes, enter the Country in which primary medical education was received: PHILIPPINES PH

6. PROFESSION OR BUSINESS: (Check One)

X (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 | 5 | 7 | (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classisification Codes.)
(See Table C)

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)
X (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check One)

___ (01) Hospital Inpatient Facility ___ (04) Nursing Home ___ (07) Other Outpatient Facility
X (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

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11. NAME OF INSTITUTION: WEST VOLUSIA MEMORIAL HOSPITAL INSTITUTION CODE: | 1 | 0 | 0 | 0 | 4 | 5 |
(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	X (10) Emergency Room
___ (03) Recovery Room	___ (07) Critical Care Unit	___ (11) Other: ___
___ (04) Labor & Delivery Room	___ (08) Special Procedure Room	___

13. DATE OF OCCURRENCE: 11/16/93

DATE REPORTED TO INSURER: 09/20/94

14. INJURED PERSON'S AGE: 82 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: M (F)

14.1 INJURED PERSON'S NAME:

STREET ADDRESS:

CITY:

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

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
A fecal impaction was diagnosed by emergency room physician and patient was sent home to be seen by a home health nurse the following day. Patient died during the night.

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.
Patient suffered a perforation of the colon.

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.
Death.

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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, missed 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---------- Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

X (09) Death

21. DATE OF SUIT, IF ANY: 3/18/96

21.1 CIRCUIT COURT CASE NUMBER: 96-01249-CI DL

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | 0 | 8 | (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)	N/A		
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 5/24/96

25. FINAL METHOD OF CLAIM DISPOSITION:
X (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.
X (04) More than 90 days after suit filed and prior to or during the course of mandatory settlement conferenc
___ (05) During trial but before court verdict.
___ (06) After court verdict and prior to filing 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)

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

28. ARBITRATION: (Check one)

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

29. WAS THERE AN ITEMIZED VERDICT? (Check One)
____ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . $ 20,000.00

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:. . . . . $ 4,514.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:. . . . . $ 694.00

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:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE . . .	$ 0.00	$ 0.00	$ 0.00
B) ESTIMATED FUTURE . . .	$ 0.00	$ 0.00	$ 0.00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS:. . . . . $ 20,000.00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS . . . . . $ 0.00

B) COST TO THE INSURER OF THE PAYMENTS . . . . . $ 0.00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF . . . . . $ 0.00

D) DID YOU PURCHASE AN ANNUITY? ____ (01) Yes X (02) No

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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)

X (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: . . . . . $ 0.0

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

A. 0% Health
B. 0% Disability
C. 0% Worker's Compensation
D. 0% Automobile
E. 0% Medicare, Medicaid & Social Security
F. 0 % Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Member has discussed case w
insurance company personnel, medical experts and defense counsel.

CONTACT PERSON: Beth Rominger
TELEPHONE: (813) 933-8517

ADDRESS: Physicians Protective Trust Fund
2901 W. Busch Blvd., Suite 503
Tampa, Florida 33618