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

9601914

DEPT. FILE NO.

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 96M05100

1. PRIMARY INSURER NAME: FRONTIER INSURANCE CO. OF N.Y. INSURER CODE: 09574
(See Table A)

2. EXCESS INSURER NAME: NONE INSURER CODE: 11111
(See Table A)

3a. HEALTH CARE PROVIDER: THIEMAN, THOMAS 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: 0040828

3c. INSURED'S NAME: THOMAS THIEMAN, M.D

STREET ADDRESS: 8251 ARVEE ROAD

CITY: NEW PORT RICHEY STATE: FL ZIP: 34653 COUNTY CODE: 28
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>RRM00010553000</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: _____)

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: 8,0,2,4,9 (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
- (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: NA

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1. NAME OF INSTITUTION: NA INSTITUTION CODE: _____ (See Table D)

2. 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
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 06/04/94
DATE REPORTED TO INSURER: 01/10/96

14. INJURED PERSON'S AGE: 27 Years (If less than one year, enter 00; if unknown, enter UNK.)
INJURED PERSON'S SEX: M (Circle one)

14.1 INJURED PERSON'S NAME _____
Last Name First and Middle Initial
STREET ADDRESS _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: REHAB FOR MENTAL RETARDATION (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NONE 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: PATIENT BECAME PREGNANT BY ANOTHER 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: NONE 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: PREGNANCY 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: / / NONE

21.1 CIRCUIT COURT CASE NUMBER: NA

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: NA (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>HARBOR BEHAVIORAL HEALTH CARE INSTITUTE</u>	<u>09544</u>	<u>955050374</u>
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 07/31/96

25. FINAL METHOD OF CLAIM DISPOSITION: ABANDONED

- (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)
- | | |
|---|--|
| <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: ----- \$ 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: ----- \$ 199 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 869 .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	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .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: NA
- | | |
|--|--------------|
| 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:

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

- A. 80 % 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: NONE

CONTACT PERSON: MARY JO DAVIS ADDRESS 6360 N.W. 5 WAY #303
TELEPHONE: (800) 408-4018 X112 FTLAUDERDALE, FL 33309