

RECEIVED

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

9602034

AUG 14 1996

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: A91-13218-89

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

1. PRIMARY INSURER NAME: Florida Physicians Insurance Company INSURER CODE: 10915183
(See Table A)

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

3a. HEALTH CARE PROVIDER: LEEDS, ~~(ESTATE OF)~~ PAUL (Estate of)
(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: 0006333

3c. INSURED'S NAME: SAME

STREET ADDRESS: 1395 N. COURTNEY PARKWAY

CITY: MERRITT ISLAND STATE: FL ZIP: 32953 COUNTY CODE: 19
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>1567</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: 80261 (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification 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: _____
 - (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: _____

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11. NAME OF INSTITUTION: N/A INSTITUTION CODE: _____ (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one) N/A

<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: 02/01/89
 DATE REPORTED TO INSURER: 05/08/91

14. INJURED PERSON'S AGE: 03 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)
BRAIN TUMOR 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: _____ 16.
DELAY IN DIAGNOSIS OF TUMOR FOLLOWING
RECOMMENDATION FOR PEDIATRICIANS TO
OBTAIN MRI

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: _____ 17.
DELAY IN DIAGNOSIS

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.
N/A

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.
MAJOR NEUROLOGICAL DEFICITS AND VENTILATOR
DEPENDENT

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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: 10/21/91

21.1 CIRCUIT COURT CASE NUMBER: 91-14466-CAR

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 19 (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>MIGUEL RIVERA MD</u>	<u>NOT KNOWN</u>	<u>NOT KNOWN</u>
2) <u>WILLIAM KRAPPENBERGER, MD</u>	<u>44050</u>	<u>" "</u>
3) <u>DONALD ARNOLD, MD</u>	<u>44050</u>	<u>" "</u>
4) <u>PEORO RODRIGUEZ</u>	<u>44010</u>	<u>" "</u>
5) <u>WVESTHOFF MEMORIAL HOSPITAL</u>	<u>NOT KNOWN</u>	<u>" "</u>

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

24. DATE OF FINAL CLAIM DISPOSITION: 06/25/96

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: ----- \$ 150,000.00

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: ----- \$ 143,308.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 48,219.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- N/A days

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

36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ N/A.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - -	\$ <u>1,000,000.00</u>	\$ <u>N/A.00</u>	\$ <u>N/A.00</u>
B) ESTIMATED FUTURE - - - -	\$ <u>26,000,000.00</u>	\$ <u>N/A.00</u>	\$ <u>N/A.00</u>

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 150,000.00

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

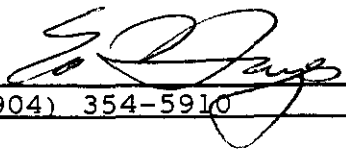
41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one)
 (01) No limit (neither party requests or agrees to voluntary binding arbitration).
 (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
 (03) \$250,000 limit (both parties accept arbitration). (See Item 42 for exception.)
 (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:
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. 100% Medicare, Medicaid & Social Security
F. ___% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: _____
NO RISK MGT NECESSARY FOR INSURED.
FOR YOUR INFORMATION, DR LEEDS DIED ON 12/31/94.

ED HAYES

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