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

9602254

DEPT. FILE NO.

SEP 13 1996

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 94-0258-10C

1. PRIMARY INSURER NAME: Legion Insurance Company INSURER CODE: 09387
(See Table A)

2. EXCESS INSURER NAME: NA INSURER CODE: _____
(See Table A)

3a. HEALTH CARE PROVIDER: Danziger, Jeffery A.
(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: 0049703

3c. INSURED'S NAME: Jeffery Danziger
STREET ADDRESS: 7251 Univ. Blvd. Ste 200
CITY: Winter Park STATE: FL ZIP: 32789-2 COUNTY CODE: 17
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>Legion</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
EXCESS INSURER:	<u>NA</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 ___ (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: NA

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11. NAME OF INSTITUTION: Winter Park Pavilion INSTITUTION CODE: WPO026
 (See Table D)

12. 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	

13. DATE OF OCCURRENCE: 01/12/95

DATE REPORTED TO INSURER: 11/09/95

14. INJURED PERSON'S AGE: 47 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: _____
Last Name First and Middle Initial

STREET ADDRESS: unk

CITY: _____ STATE: FL ZIP: 32789

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Alcohol abuse, suicide (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: Suicide
 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: alleg. failure to diagnos suicide
 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
 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 dela;
- (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: NA / /

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>Winter Park Pavilion</u>	<u>unk</u>	<u>unk</u>
2)	<u>Dr. unk Krotenberg</u>	<u>unk</u>	<u>unk</u>
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

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

- (01) Yes
- (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 9/6/96

25. FINAL METHOD OF CLAIM DISPOSITION: NA

- (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) NA

- (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"/> (02) Directed verdict for plaintiff.
<input type="checkbox"/> (03) Directed verdict for defendant.
<input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff.
<input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant.
<input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (07) Judgment for the defendant.
<input type="checkbox"/> (08) Judgment for the plaintiff after appeal.
<input type="checkbox"/> (09) Judgment for the defendant after appeal.
<input type="checkbox"/> (10) Other
<input type="checkbox"/> (11) Summary judgment for the plaintiff.
<input type="checkbox"/> (12) Summary judgment for the defendant. |
|---|--|

28. ARBITRATION: (Check one) *NA*
- | | |
|---|--|
| <input type="checkbox"/> (01) Claim not subject to arbitration.
<input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.
<input type="checkbox"/> (04) Award for defendant. |
|---|--|

29. Was there an itemized verdict? (Check one) *NA*
- (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: - - - - - \$ 0.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 0.00

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>6</u> .00	\$ <u>6</u> .00	\$ <u>6</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:

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 (02) No *NA*

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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) NA
 (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: NA
----- \$ 0 .00

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

A. ___% Health	D. ___% Automobile
B. ___% Disability	E. ___% Medicare, Medicaid & Social Security
C. ___% Workers' Compensation	F. ___% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: None
No negligence

JOAN R. BRECKENRIDGE
PROFESSIONAL RISK MANAGEMENT
SERVICES
1000 WILSON BOULEVARD, STE 2500
ARLINGTON, VA 22209

CONTACT PERSON: _____ ADDRESS _____
TELEPHONE: (703) 907.3932