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

9600716

FEB 21 1996

DEPT. FILE NO.

BUREAU OF PROPERTY AND CASUALTY FORMS & RATES
INSURER'S CLAIM NUMBER: 2711

PRIMARY INSURER NAME: Frontier Insurance Co. of New York INSURER CODE: 0,9,5,7,4
(See Table A)

EXCESS INSURER NAME: n/a INSURER CODE: 1,1,1,1
(See Table A)

HEALTH CARE PROVIDER: Winters, Paul Regan
(Last Name, First and Middle Name or Hospital Name from Table D)

IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 00,214,24

INSURED'S NAME: Paul Winters, M.D.

HOME ADDRESS: 13801 Bruce B. Downs Blvd.

CITY: Tampa STATE: FL ZIP: 33,613 COUNTY CODE: 03
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>R-RM-0000762-3</u>	<u>\$ 1,000,000 .00</u>	<u>\$ 3,000,000 .00</u>
EXCESS INSURER:	<u>0</u>	<u>\$ 0 .00</u>	<u>\$ 0 .00</u>

IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? (01) Yes (02) No (If yes, enter the country in which primary medical education was received: n/a)

- 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

SPECIALTY CODE: 80,2,8,8
(See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

- 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)

- 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

IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY
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NAME OF INSTITUTION: University Community Hospital ^{Tampa} INSTITUTION CODE: 1,0,0,1,7,3
(See Table D)

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 | |

DATE OF OCCURRENCE: 03, 28, 91

DATE REPORTED TO INSURER: 11, 10, 93

INJURED PERSON'S AGE: 71 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PER: M F (Circle one)

1 INJURED PER

STATE

CITY: _____

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Right carotid endarterectomy. 15.
6. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
N/A 16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Alleged delay in response to notice of neurological changes post-op in 71 yr. old female 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:
Ultra sound ordered for following a.m. 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:
Neurological damage. 19.

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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, missed 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

DATE OF SUIT, IF ANY: 4/22/94

1. CIRCUIT COURT CASE NUMBER: 94-02101

2. COUNTY CODE OF COUNTY SUIT FILED IN: 03 (SEE TABLE B)

3. 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>University Community Hospital, Tampa</u>	<u>Unknown</u>	<u>Unknown</u>
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

14. DATE OF FINAL CLAIM DISPOSITION: 02/07/96

15. 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-judgment relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claim or suit abandoned.

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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.

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.

Was there an itemized verdict? (Check one)

- (01) Yes
- (02) No (If yes, please attach copy of settlement or verdict.)

- 1. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 1,076,761 .00
- 2. AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: ----- \$ 0 .00
- 3. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 0 .00
- 4. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 90,856 .00
- 5. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 37,177 .00
- 6. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- 0 days
- 7. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- 0 days
- 8. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ 0 .00

9. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE	\$ <u>1,474,102</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00

10. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 1,076,761 .00

11. 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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BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: n/a

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.

IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMIC DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: - - - - - \$ n/a .00

COLLATERAL SOURCE INFORMATION:

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

- | | |
|---|---|
| A. <input type="checkbox"/> % Health | D. <input type="checkbox"/> % Automobile |
| B. <input type="checkbox"/> % Disability | E. <input type="checkbox"/> % Medicare, Medicaid & Social Security <u>n/a</u> |
| C. <input type="checkbox"/> % Workers' Compensation | F. <input type="checkbox"/> % Other sources, specify: _____ |

SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: None

CONTACT PERSON: Bill Cunningham ADDRESS 6360 NW 5th Way Suite 303
TELEPHONE: (305) 491-6078 Ft. Lauderdale, FL 33309