JAN 17 1997

BUREAU OF PROPERTY & CASUALTY FORMS & RATES

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

9700147
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: N/A

1. PRIMARY INSURER NAME: MAYO INSURANCE COMPANY LTD. INSURER CODE: 08751 (See Table A)

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

3a. HEALTH CARE PROVIDER: RUBINO, FRANK 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: 0000025

3c. INSURED'S NAME: MAYO CLINIC JACKSONVILLE

STREET ADDRESS: 4500 SAN PABLO ROAD

CITY: JACKSONVILLE STATE: FL ZIP: 32224 COUNTY CODE: 02 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	272-1-05001-01	$ 1,000,000 .00	$ 5,000,000 .00
EXCESS INSURER:	N/A	$ N/A .00	$ N/A .00

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

6. PROFESSION OR BUSINESS: (Check one)
XX (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 (See Table C) (Applies to physicians, surgeons, and dentists. 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.
XX (03) In the specialty in Item 7 and another. Enter the additional specialty code here: 80249 (See Table C)
___ (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check one)
XX (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

0. 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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10-0151

. NAME OF INSTITUTION: ST. LUKE'S HOSPITAL INSTITUTION CODE: _____ (See Table D)

. LOCATION OF INSTITUTIONAL INJURY: (Check one)

___ (01) Patient's Room	___ (05) Physical Therapy Dept.	___ (09) Radiology
XX (02) Operating Suite	___ (06) Nursery	___ (10) Emergency Room
___ (03) Recovery Room	___ (07) Critical Care Unit	___ (11) Other _____
___ (04) Labor & Delivery Room	___ (08) Special Procedure Room	_____

. DATE OF OCCURRENCE: 04-01-94 ~~APRIL / - JUNE 1994~~

DATE REPORTED TO INSURER: 03/08/95

. INJURED PERSON'S AGE: 79 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERS ... M (F) (Circle one)

.1 INJURED PERS

STREE

CITY: _____

. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Cerebral amyloid angiopathy and vasculitis	(LEAVE BLANK) 15.	
. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: None; patient's condition presented with a 3cm mass on MRI in the right frontal lobe which caused seizures. The mass enlarged over time and was thought to most likely represent a tumor.	16.	
. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: A craniotomy was performed to reduce the size of the mass to relieve pressure on the brain and to obtain tissue to make a diagnosis.	17.	
. 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: After the craniotomy the patient had a seizure and hemorrhaged requiring a second craniotomy to remove the hemorrhage.	18.	
. 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: The patient experienced right sided weakness and aphasia which improved over time with rehabilitation. The patient died 1 year later, but the cause of death was unknown as no autopsy was performed	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.

X (09) Death

21. DATE OF SUIT, IF ANY: 08/18/95

21.1 CIRCUIT COURT CASE NUMBER: 95-04237 CA

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 02 (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)	WHAREN, ROBERT E., JR.	08751	N/A
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 01/06/97 (Final Judgment Awarding Costs to Defendant)

25. FINAL METHOD OF CLAIM DISPOSITION:
___(01) Settled by parties.
XX (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.
XX (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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7. 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.
XX (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.

8. ARBITRATION: (Check one) N/A

___(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.

9. Was there an itemized verdict? (Check one)

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

10. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 0.00

10.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: - $ 0.00

11. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - $ 0.00

12. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ATTORNEYS FEES AS OF 12/10/96 - $ 82,761.00

13. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: APPROX. AS OF 12/19/96 - $ 37,113.00

14. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - - 0 days

15. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - - 0 days

16. INJURED PERSON'S GROSS WEEKLY INCOME: - $ 0.00

17. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ UNK .00	$ 0 .00	$ UNK .00
B) ESTIMATED FUTURE - - - -	$ 0 .00	$ 0 .00	$ 0 .00

18. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - $ 0.00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ N/A .00

B) COST TO THE INSURER OF THE PAYMENTS - $ N/A .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ N/A .00

D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes ___ (02) No N/A

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0. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

1. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one) N/A

___ (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.

2. 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

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

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

4. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: N/A

CONTACT PERSON: JOANNE L. MARTIN
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4500 SAN PABLO ROAD
JACKSONVILLE FL 32224