

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

9702045

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 96M05257

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

2. EXCESS INSURER NAME: N/A INSURER CODE: 1,1,1,1,1  
(See Table A)

3a. HEALTH CARE PROVIDER: Singh, Hardeep  
(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: 0,0,5,5,1,9,3

3c. INSURED'S NAME: Hardeep Singh, M.D.

STREET ADDRESS: 3820 Northdale Blvd. #300B

CITY: Tampa STATE: FL ZIP: 33162 COUNTY CODE: 03  
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
4. PRIMARY INSURER:	<u>R-ML-0300779-4</u>	<u>\$ 1,000,000 .00</u>	<u>\$ 3,000,000 .00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ N/A .00</u>	<u>\$ N/A .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: India) IN

6. PROFESSION OR BUSINESS: (Check one)

<input checked="" type="checkbox"/> (01) Physicians & Surgeons	<input type="checkbox"/> (04) Dentist	<input type="checkbox"/> (07) Crisis Stabilization Unit
<input type="checkbox"/> (02) Hospitals	<input type="checkbox"/> (05) Abortion Clinics	<input type="checkbox"/> (08) Health Maintenance Organization
<input type="checkbox"/> (03) Podiatrists	<input type="checkbox"/> (06) Ambulatory Surgical Centers	

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)

<input type="checkbox"/> (01) Hospital Inpatient Facility	<input type="checkbox"/> (04) Nursing Home	<input type="checkbox"/> (07) Other Outpatient Facility
<input type="checkbox"/> (02) Emergency Room	<input type="checkbox"/> (05) Physician's Office	<input type="checkbox"/> (08) Other Location
<input type="checkbox"/> (03) Hospital Outpatient Facility	<input checked="" type="checkbox"/> (06) Patient's Home	<input type="checkbox"/> (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: N/A

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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: 12/31/94  
 DATE REPORTED TO INSURER: 02/13/96

14. INJURED PERSON'S AGE: 33 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: \_\_\_\_\_  
 \_\_\_\_\_ and Middle Initial \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Depression (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: The Insd signed off on 12/16/94 on a treatment plan that was devised by another therapist. The treatment plan noted the patient was not suicidal. The patient was to be referred to Insd for psychotherapy. He committed suicide 12/31/94. 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: N/A 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 caused by suicide. 19.



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27. COURT: (Check one)
- |   |  |
|---|--|
| <input checked="" type="checkbox"/> (01) No court proceedings.<br><input type="checkbox"/> (02) Directed verdict for plaintiff.<br><input type="checkbox"/> (03) Directed verdict for defendant.<br><input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff.<br><input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant.<br><input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (07) Judgment for the defendant.<br><input type="checkbox"/> (08) Judgment for the plaintiff after appeal.<br><input type="checkbox"/> (09) Judgment for the defendant after appeal.<br><input type="checkbox"/> (10) Other<br><input type="checkbox"/> (11) Summary judgment for the plaintiff.<br><input type="checkbox"/> (12) Summary judgment for the defendant. |
|---|--|

28. ARBITRATION: (Check one)
- |  |  |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.<br><input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.<br><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: - - - - -	\$	13,414. .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - -	\$	1,761. .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 - - - - -	\$ -0- .00	\$ -0- .00	\$ -0- .00
B) ESTIMATED FUTURE - - - - -	\$ -0- .00	\$ -0- .00	\$ -0- .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:    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: N/A  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: - - - - - \$ N/A .00

43. 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 |
| C. <input type="checkbox"/> % Workers' Compensation | F. <input type="checkbox"/> % Other sources, specify: <u>N/A</u>   |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured discussed case with defense counsel and insurance personnel.  
\_\_\_\_\_  
\_\_\_\_\_

CONTACT PERSON: Jill Cannon  
TELEPHONE: (407) 648-4028

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Orlando, FL 32801