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

9700940

APR 28 1997

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 96M06003

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

1. PRIMARY INSURER NAME: FRONTIER INSURANCE COMPANY OF NEW YORK INSURER CODE: 09574
(See Table A)

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

3a. HEALTH CARE PROVIDER: Cobiella, Robert Salvador
(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: 0050662

3c. INSURED'S NAME: Robert Cobiella

STREET ADDRESS: 612 NW Sunset DR.

CITY: STUART STATE: FL ZIP: 34994 COUNTY CODE: 24
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>CM0500959-6</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>

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: ARGENTINA)

AR

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: 80249 (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: N/A

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

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)
 (01) Patient's Room ___ (05) Physical Therapy Dept. ___ (09) Radiology
___ (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

13. DATE OF OCCURRENCE: 5, 5, 94
DATE REPORTED TO INSURER: 7, 22, 96

14. INJURED PERSON'S AGE: 35 Years (If less than one year, enter 00; if unknown, enter UNK.)
INJURED PERSON'S SEX: M F (Circle one)

14.1 INJUF

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED; (LEAVE BLANK)
Depression and suicidal ideations 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.
NONE

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
Alleges failure to instruct patient on medication side effects resulted in depressed state and attempted suicide.

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.
DR. Cobiella prescribed XANAX, THORAZINE, AND INDEOL

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.
Mental Anguish

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

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: N/A

21.1 CIRCUIT COURT CASE NUMBER: N/A

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: N/A (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>SLATER, VICTOR</u>	<u>09574</u>	<u>96M06051</u>
2)	<u>TINGLE, DAVID</u>	<u>09574</u>	<u>96M06050</u>
3)	<u>NEW HORIZONS</u>	<u>unknown</u>	<u>unknown</u>
4)	_____	_____	_____
5)	_____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 4/24/97

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.

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

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

28. ARBITRATION: (Check one)
- | | |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration. | <input type="checkbox"/> (03) Award for plaintiff. |
| <input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <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: ----- \$ 0.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 3535.00

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:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</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 | ----- \$ <u>0</u> .00 |
| B) COST TO THE INSURER OF THE PAYMENTS | ----- \$ <u>0</u> .00 |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF | ----- \$ <u>0</u> .00 |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" type="checkbox"/> (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. ___% Health | D. ___% Automobile |
| B. ___% Disability | E. ___% Medicare, Medicaid & Social Security |
| C. ___% Workers' Compensation | F. ___% Other sources, specify: <u>N/A</u> |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:

The insured has consulted with medical experts, defense counsel, and claims personnel regarding this incident.

CONTACT PERSON: Deborah Crosby ADDRESS 6360 NW 5th Way Suite 303
TELEPHONE: 954 491-6078 FT LAUDERDALE, FL 33309