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FL DEPT OF INSURANCE

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

9900777
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 95-23015-01-041

1. PRIMARY INSURER NAME: PRONATIONAL INSURANCE COMPANY — INSURER CODE: | 4 | 4 | 0 | 5 | 0 | (See Table A)

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

3a. HEALTH CARE PROVIDER: ANDRIOLA, MICHAEL JOHN
(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 | 1 | 2 | 5 | 0 | 3 |

3c. INSURED'S NAME: MICHAEL J ANDRIOLA, MD

STREET ADDRESS: BUILDING A, 1011 JEFFORDS STREET

CITY: CLEARWATER STATE: | F | L | ZIP: | 3 | 4 | 6 | 1 | 6 | COUNTY CODE: | 0 | 4 | (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	1005702	$ 1,000,000.00	$ 3,000,000.00
EXCESS INSURER:	N/A	$ 0.00	$ 0.00

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? ____ (01) Yes _x_ (02) No (If yes, enter the Country in which primary medical education was received: ________

6. PROFESSION OR BUSINESS: (Check One)
_x_ (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: | 8 | 0 | 2 | 6 | 1 | (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classisification Codes.)

8. BOARD CERTIFICATION: (Check One)
_x_ (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: ________ (See Table C)
___ (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check One)
_x_ (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

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11. NAME OF INSTITUTION: MORTON F PLANT HOSPITAL   INSTITUTION CODE: | 1 | 0 | 0 | 1 | 2 | 7 |
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

X (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: 07/10/94

DATE REPORTED TO INSURER: 06/13/95

14. INJURED PERSON'S AGE: 34 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:

STREET ADDRESS:

CITY:

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
Colloid cyst.

(LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
N/A

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Patient was hospitalized for evaluation of severe headaches. A CT scan indicated a questionable cyst in the third ventricle. Following a diagnostic MRI, the patient arrested and expired.

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:
Patient was being evaluated for severe headaches with a CT and MRI.

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:
Patient arrested and expired.

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.

Temporary
___ (02) Insignificant--- Lacerations, contusions, minor scars, rash. No delay.
___ (03) Minor----------- Infections, missed fracture, fall in hospital. Recovery delayed.
___ (04) Major----------- Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

Permanent
___ (05) Minor----------- Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
___ (06) Significant----- Deafness, loss of limb, loss of eye, loss of one kidney or lung.
___ (07) Major----------- Paraplegia, blindness, loss of two limbs, brain damage.
___ (08) Grave----------- Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

_X_ (09) Death

21. DATE OF SUIT, IF ANY: 2/01/96

21.1 CIRCUIT COURT CASE NUMBER: 96-604 CI 20

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | 0 | 4 | (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)	Macik, Bernard A., M.D.	80261	96-23015-02-055
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 5/21/99

25. FINAL METHOD OF CLAIM DISPOSITION:
_X_ (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.
_X_ (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 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)

- X (01) No court proceedings.
- ___ (02) Directed verdict for plaintiff.
- ___ (03) Directed verdict for defendant.
- ___ (04) Judgement notwithstanding the verdict for plaintiff.
- ___ (05) Judgement notwithstanding the verdict for defendant.
- ___ (06) Judgement for the plaintiff.
- ___ (07) Judgement for the defendant.
- ___ (08) Judgement for the plaintiff after appeal.
- ___ (09) Judgement for the defendant after appeal.
- ___ (10) Other
- ___ (11) Summary judgement for the plaintiff.
- ___ (12) Summary judgement for the defendant.

28. ARBITRATION: (Check one)

- X (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.

29. WAS THERE AN ITEMIZED VERDICT? (Check One)
___ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . $ 480,000.00

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:. . . . $ 39,293.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:. . . . $ 22,090.00

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 . . .	$ 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:. . . . $ 480,000.00

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 X (02) No

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

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check One)

X (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-ECONOMICAL DAMAGES IS DIFFERENT THAN $250,000, THEN INDICATE THE MODIFIED LIMIT: . . . . $ 0.00

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

A. 0% Health
B. 0% Disability
C. 0% Worker's Compensation
D. 0% Automobile
E. 0% Medicare, Medicaid & Social Security
F. 0 % Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured has discussed case with insurance company personnel, medical experts and defense counsel.

CONTACT PERSON: Beth Rominger
TELEPHONE: (813) 933-8517

ADDRESS: ProNational Insurance Company
2901 W. Busch Blvd., Suite 503
Tampa, Florida 33618