FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# 82-3427

10441

PRIMARY CARRIER
Company Code 4 4 0 5 0 (Florida Certificate of Authority Number)

Company Name PHYSICIANS PROTECTIVE TRUST FUND

Policy Number 3533

EXCESS CARRIER
Company Code (Florida Certificate of Authority Number)

Company Name

Policy Number

Calendar Year Claim Closed 8 2 FCC M M 1 IAC 3

Insured John Acevedo, M.D.

Address 10868 N. W. 21st Place, Coral Springs, FL County Code 1 0

(1) Speciality Anesthesia Code 0 1

(2) Date of Incident (Month, Day, Year) 0 9 0 3 8 1

(3) Date submitted for mediation (Month, Day, Year)

(4) Disposition of mediation (check one):

(1) ☐ Plaintiff (2) ☐ Defendant (3) ☐ No final conclusion

(5) Date of suit, if filed (Month, Day, Year)

(6) Disposition of incident (check one):

(1) ☐ Final Judgment (2) ☒ Settlement

(3) ☐ Final Disposition Not Resulting in Payment on Behalf of the Insured

(7) Date and amount of Judgment or Settlement (Month, Day, Year) 0 9 2 1 8 2

A. Primary Indemnity $ 150.[redacted] C. Excess Indemnity $

B. Primary Defense $ 0 D. Excess Defense Costs $

8) Summary Judgment (1) ☐ For Plaintiff (2) ☐ For Defendant

9) Directed Verdict (1) ☐ For Plaintiff (2) ☐ For Defendant

10) Trial (1) ☐ YES (2) ☒ NO

11) Date and reason for final disposition, if no settlement or judgment:

(Month, Day, Year) 1 0 1 8 8 2

12) Include brief summary of occurrence which created claim on back.

Form No. DI4-303 Prepared by Sergio Moreno/cg

Tooth loosened during surgery.