

FLORIDA DEPARTMENT OF INSURANCE  
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

09C001  
FILE# \_\_\_\_\_

PRIMARY CARRIER

Company Code 01470 (Florida Certificate of Authority Number)

0418

Company Name The St. Paul Insurance Companies

Policy Number 509JH 7837

EXCESS CARRIER

Company Code      (Florida Certificate of Authority Number)

Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Calendar Year Claim Closed 83 FCC MMI IAC 3

Insured Andriola, Chartered - Michael A. Andriola

Address 1011 Jeffords St., Clearwater, Fla. 33516 County Code 04

(1) Speciality Neurology & neurosurgery Code 09

(2) Date of Incident (Month, Day, Year) 09/03/79

(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) 03/3/83

(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)     

A. Primary Indemnity \$ 0 C. Excess Indemnity \$ \_\_\_\_\_

B. Primary Defense \$ 2541 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) 09/20/83 voluntary dismissal

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

(12) Plaintiff alleged improper treatment of arm  
resulted in permanent injury