

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

83M005423

00046

PRIMARY CARRIER

Company Code 09085 (Florida Certificate of Authority Number)

Company Name ARGONAUT INSURANCE COMPANY

Policy Number 83 - 318 - 603055

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 83
02 FCC MM1 IAC 3

Insured HERMAN M. ZEIDMAN, M.D.

Address 3100 Estates Drive, Pompano Beach, FL 33060

County Code 10

(1) Speciality GENERAL PRACTITIONER Code 06

(2) Date of Incident (Month, Day, Year) 092678

(3) Date submitted for mediation (Month, Day, Year) 092678

(4) Disposition of mediation (check one):
(1) Plaintiff (2) Defendent (3) No final conclusion

(5) Date of suit, if filed (Month, Day, Year) 032879

(6) Disposition of incident (check one):
(1) Final Judgement (2) Settlement
(3) Final Disposition not resulting in payment on behalf of the Insured

(7) Date and amount of Judgement or Settlement (Month, Day, Year) 031882
A. Primary Indemnity \$ 10,000. C. Excess Indemnity \$ N/A
B. Primary Defense \$ 22,721. D. Excess Defense Costs \$ N/A

(8) Summary Judgement (1) For Plaintiff (2) For Defendent

(9) Directed Verdict (1) For Plaintiff (2) For Defendent

(10) Trial (1) YES (2) NO

(11) Date and reason for final disposition, if no settlement or judgement:
(Month, Day, Year)

(12) Include brief summary of occurrence which created claim on back.
ALLEGES FAILURE TO DIAGNOSE TUMOR IN LARYNX.

Prepared By WILLIAM J. WATSON