

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

01393

FILE#
445 L 32814

PRIMARY CARRIER

Company Code (Florida Certificate of Authority Number) --
Company Name The Hartford Insurance Group - FMMJUA
Policy Number 60 ID 104481

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)
Company Name _____
Policy Number _____

Calendar Year Claim Closed FCC IAC
Insured Jerusalem, Dr. George

Address _____ County Code

(1) Surgery Code Speciality Internal Medicine Code

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

(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)

A. Primary Indemnity \$ _____ C. Excess Indemnity \$ _____
B. Primary Defense \$ _____ 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) No liability - Dismissed.

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

83 02521

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

FILE# 10180-0

PRIMARY CARRIER

Company Code 4 4 0 3 0 (Florida Certificate of Authority Number)

Company Name FLORIDA OSTEOPATHIC INSURANCE TRUST

Policy Number _____

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 8 3 FCC MM 1 IAC 3

Insured Aurelio A. Ortiz, M.D.

Address 2108 Moore Drive, Dade City, Florida, 33525

County Code 2 8

(1) Speciality General/Family Practice Code 1 3

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

(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) 0 1 2 7 8 1

(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 2 1 1 8 3

A. Primary Indemnity \$ \$20,677.00 C. Excess Indemnity \$ _____

B. Primary Defense \$ \$7091.00 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)

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

17Y0 Female tx by physician in Emergency Room and transferred to Shands Hospital, post-gunshot wound. Died during surgery on table.