

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

1777

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 4837288-81

1. PRIMARY INSURER NAME: Florida Physicians' Insurance Reciprocal INSURER CODE: 04160
(See Table A)
2. EXCESS INSURER NAME: _____ INSURER CODE: _____
(See Table A)
3. INSURED'S NAME: Beckman, ~~KAA~~, Kendall M.
(last name, first name, middle name)
STREET ADDRESS: 511-B N. Harbor City Blvd.
CITY, STATE: Melbourne, Fl. ZIP: 32935 COUNTY CODE: 19
(See Table B)
4. PRIMARY POLICY NUMBER: 8301-09448 EXCESS POLICY NUMBER: _____
PRIMARY POLICY LIMITS: \$ 500,000.00 (per claim) EXCESS POLICY LIMITS: \$ _____ .00 (per claim)
\$ _____ .00 (per aggregate) \$ _____ .00 (per aggregate)
5. Is the insured physician a Foreign Medical Graduate? If yes, enter the country in which primary medical education
was received: _____
 (1) Yes (2) No
6. PROFESSION OR BUSINESS: (check one)
 (1) Physicians & Surgeons (4) Other Medical Professionals (7) Other Health Care Facilities
 (2) Hospitals (5) Clinics
 (3) Podiatrists (6) Ambulatory Surgical Centers
7. SPECIALTY CODE: 80239 (Applies to physicians, surgeons, and other health care professionals.
(See Table C) Use ISO Common Statistical Base Classification Codes.)
8. BOARD CERTIFICATION: (check one)
 (1) In specialty coded in Item 7, above.
 (2) In a different specialty.
 (3) In both the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____
 (4) Insured is not board certified. (See Table C)
9. PLACE WHERE INJURY OCCURRED: (check one)
 (1) Hospital Inpatient Facility (4) Nursing Home (7) Other Outpatient Facility
 (2) Emergency Room (5) Physician's Office (8) Other Location
 (3) Hospital Outpatient Facility (6) Patient's Home (9) Other Hospital/Institution
10. If Place of Injury (above) is checked as (8) Other, then
provide a description of the place where the injury occurred: _____
11. NAME OF INSTITUTION: HOLMES REGIONAL MED CENTER INSTITUTION CODE: LEP019
(See Table B)
12. LOCATION OF INSTITUTIONAL INJURY: (check one)
 (1) Patient's Room (4) Labor & Delivery Room (7) Critical Care Unit
 (2) Operating Suite (5) Physical Therapy Dept. (8) Special Procedure Room
 (3) Recovery Room (6) Nursery (9) Radiology
13. DATE OF OCCURRENCE: 06/06/81
DATE REPORTED TO INSURER: 06/20/83
14. INJURED PERSON'S AGE: 45 INJURED PERSON'S SEX: M E (circle one)

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DEPARTMENT FILE NO.
 INSURER'S CLAIM NO. 083-1588-81

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

COMPRESSION FX OF T-12

(LEAVE BLANK)

15.

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

PT WAS FOUND TO HAVE COCCYX FRACTURE
 BUT FX OF T-12 WAS MISSED BY
 RADIOLOGIST (WHO WAS NOT NAMED IN SUIT)

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:

DIAGNOSIS OF T-12 FX WAS MADE 1 MONTH
 AFTER ORIGINAL DIAGNOSIS.

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:

SEE 16 ABOVE

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:

SEE 17 ABOVE

19.

20. SEVERITY OF INJURY: (check only one -- rate most serious injury if several are involved.)

- (1) Emotional only --- Fright, no physical damage.
- (2) Insignificant --- Lacerations, contusions, minor scars, rash. No delay.
- Temp- (3) Minor --- Infections, misset fracture, fall in hospital. Recovery delayed.
- orary (4) Major --- Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
- (5) Minor --- Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
- Perma- (6) Significant --- Deafness, loss of limb, loss of eye, loss of one kidney or lung.
- nent (7) Major --- Paraplegia, blindness, loss of two limbs, brain damage.
- (8) Grave --- Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
- (9) Death

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DEPARTMENT FILE NO.
 INSURER'S CLAIM NO. 483-7288-81

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 3,333.00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ _____ .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 17,827.00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ _____ .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- _____ days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- _____ days
36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	\$ _____ .00	\$ _____ .00	\$ _____ .00
B) ESTIMATED FUTURE	\$ _____ .00	\$ _____ .00	\$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ _____ .00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ _____ .00
- B) COST TO THE INSURER OF THE PAYMENTS ----- \$ _____ .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- \$ _____ .00
- D) DID YOU PURCHASE AN ANNUITY? (1) Yes (2) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: _____

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: _____

CONTACT PERSON: PAULINE J CURRAN ADDRESS: PO Box 44033
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