

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

86 00172

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. AS6-9152-85

1. PRIMARY INSURER NAME: Fla. Physicians Ins. Co. INSURER CODE: 04160
(See Table A)
2. EXCESS INSURER NAME: _____ INSURER CODE: _____
(See Table A)
3. INSURED'S NAME: Collins, James E.
(last name, first name, middle name)
STREET ADDRESS: 689 Jamiami Trail, N.
CITY, STATE: Naples, Fl. ZIP: 33940 COUNTY CODE: 64
(See Table B)
4. PRIMARY POLICY NUMBER: 8501-10637 EXCESS POLICY NUMBER: _____
PRIMARY POLICY LIMITS: \$ 1,000,000.00 (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: 28.0249 (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: NAPLES COMMUNITY HOSPITAL INSTITUTION CODE: 100018
(See Table D)
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: 1, 8, 85
DATE REPORTED TO INSURER: 10/14/85
14. INJURED PERSON'S AGE: 49 INJURED PERSON'S SEX: M (circle one)

4

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

(LEAVE BLANK)

15.

LACERATION OF LEFT WRIST

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

16.

NONE

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:

17.

NO CLAIM-RECORDS REQUEST

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:

18.

STITCHED LACERATION IN E.R.

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:

19.

RECORD REQUEST

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

4

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21. DATE OF SUIT, IF ANY: N/A

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S CODE NUMBER AND THE COMPANION CLAIM FILE IDENTIFICATION NUMBER:

	DEFENDANT'S NAME (last name, first name)	INSURER CODE NO.	INSURER FILE ID.
1)	<u>N/A</u>	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (check one)

- (1) Yes (2) No

24. DATE OF FINAL CLAIM DISPOSITION: 1/29/86

25. FINAL METHOD OF CLAIM DISPOSITION:

- (1) Settled by parties.
 (2) Disposed of by a court.
 (3) Disposed of by arbitration.

26. SETTLEMENT: (check one)

- (1) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
 (2) After arbitration is initiated or prior to suit being filed.
 (3) Within 90 days of suit being filed.
 (4) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
 (5) Prior to completion of the swearing of the jury.
 (6) Prior to filing of the notice of appeal.
 (7) After notice of appeal is filed or post-judgment relief or action is required for recovery.
 (8) During appeal.
 (9) After appeal.
 (0) Claim or suit abandoned.

27. COURT: (check one)

- (1) No court proceedings. (6) Judgment for the plaintiff.
 (2) Directed verdict for plaintiff. (7) Judgment for the defendant.
 (3) Directed verdict for defendant. (8) Judgment for the plaintiff after appeal.
 (4) Judgment notwithstanding the verdict for the plaintiff. (9) Judgment for the defendant after appeal.
 (5) Judgment notwithstanding the verdict for the defendant. (0) Other.

28. ARBITRATION: (check one)

- (1) Claim not subject to arbitration. (3) Award for plaintiff.
 (2) Claim subject to arbitration, but previously coded disposition reached in lieu of award. (4) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (check one)

- (1) Yes (2) No (If yes, please attach copy of settlement or verdict.)

6

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ NONE .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ NONE .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ NONE .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 233.00 .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	\$ <u>N/A</u> .00	\$ <u>—</u> .00	\$ <u>—</u> .00
B) ESTIMATED FUTURE	\$ <u>N/A</u> .00	\$ <u>—</u> .00	\$ <u>—</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ N/A .00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ N/A .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: _____

NONE

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

NONE

CONTACT PERSON: Edward L. Luther ADDRESS 1000 Riverside Ave.
 TELEPHONE: (904) 354-5910 Opalochville, FL 32207