

RECORDED

JUL 7 1986

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

8600790

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 95-81

BUREAU OF RATES

South Broward Hospital District Physician's
Professional Liability Insurance Trust

1. PRIMARY INSURER NAME: _____ INSURER CODE: 44060
(See Table A)
2. EXCESS INSURER NAME: Florida Patients Compensation Fund INSURER CODE: 46010
(See Table A)
3. INSURED'S NAME: Subias, Eusebio
(last name, first name, middle name)
STREET ADDRESS: 1711 Buchanan Street
Hollywood, Florida
CITY, STATE: _____ ZIP: 33020 COUNTY CODE: 10
(See Table B)
4. PRIMARY POLICY NUMBER: 253 EXCESS POLICY NUMBER: 7315
PRIMARY POLICY LIMITS: \$ 100,000.00 (per claim) EXCESS POLICY LIMITS: \$ UNK .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)
- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> (1) Physicians & Surgeons | <input type="checkbox"/> (4) Other Medical Professionals | <input type="checkbox"/> (7) Other Health Care Facilities |
| <input type="checkbox"/> (2) Hospitals | <input type="checkbox"/> (5) Clinics | |
| <input type="checkbox"/> (3) Pediatricists | <input type="checkbox"/> (6) Ambulatory Surgical Centers | |

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and other health care professionals.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (check one)
- | | |
|---|---------------|
| <input type="checkbox"/> (1) In specialty coded in Item 7, above. | |
| <input type="checkbox"/> (2) In a different specialty. | |
| <input type="checkbox"/> (3) In both the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____ | |
| <input checked="" type="checkbox"/> (4) Insured is not board certified. | (See Table C) |

9. PLACE WHERE INJURY OCCURRED: (check one)
- | | | |
|---|--|---|
| <input type="checkbox"/> (1) Hospital Inpatient Facility | <input type="checkbox"/> (4) Nursing Home | <input type="checkbox"/> (7) Other Outpatient Facility |
| <input type="checkbox"/> (2) Emergency Room | <input checked="" type="checkbox"/> (5) Physician's Office | <input type="checkbox"/> (8) Other Location |
| <input type="checkbox"/> (3) Hospital Outpatient Facility | <input type="checkbox"/> (6) Patient's Home | <input type="checkbox"/> (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: NA INSTITUTION CODE: _____
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (check one) NA
- | | | |
|--|---|---|
| <input type="checkbox"/> (1) Patient's Room | <input type="checkbox"/> (4) Labor & Delivery Room | <input type="checkbox"/> (7) Critical Care Unit |
| <input type="checkbox"/> (2) Operating Suite | <input type="checkbox"/> (5) Physical Therapy Dept. | <input type="checkbox"/> (8) Special Procedure Room |
| <input type="checkbox"/> (3) Recovery Room | <input type="checkbox"/> (6) Nursery | <input type="checkbox"/> (9) Radiology |

13. DATE OF OCCURRENCE: 7/1/82
DATE REPORTED TO INSURER: 11/30/82

14. INJURED PERSON'S AGE: UNK INJURED PERSON'S SEX: M (circle one)

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15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: UNK	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NA	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Alleged negligence	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: NA	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: NA	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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21. DATE OF SUIT, IF ANY: 11/ 8 / 82

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

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

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

(1) Yes (2) No

24. DATE OF FINAL CLAIM DISPOSITION: 6 / 24 / 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.
 (10) Claim or suit abandoned.

27. COURT: (check one)

<input type="checkbox"/> (1) No court proceedings.	<input checked="" type="checkbox"/> (6) Judgment for the plaintiff.
<input type="checkbox"/> (2) Directed verdict for plaintiff.	<input type="checkbox"/> (7) Judgment for the defendant.
<input type="checkbox"/> (3) Directed verdict for defendant.	<input type="checkbox"/> (8) Judgment for the plaintiff after appeal.
<input type="checkbox"/> (4) Judgment notwithstanding the verdict for the plaintiff.	<input type="checkbox"/> (9) Judgment for the defendant after appeal.
<input type="checkbox"/> (5) Judgment notwithstanding the verdict for the defendant.	<input type="checkbox"/> (10) 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.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 25,000 .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ UNK .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 60712 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 16384 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- UNK days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- UNK days
36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ UNK .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE -----	\$ <u>UNK</u> .00	\$ <u>UNK</u> .00	\$ <u>UNK</u> .00
B) ESTIMATED FUTURE -----	\$ <u>UNK</u> .00	\$ <u>UNK</u> .00	\$ <u>UNK</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ -0- .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: UNK

CONTACT PERSON: Bea Antonoff ADDRESS 921 N. 35 Avenue
 TELEPHONE: (305) 987-1455 Hollywood, Florida 33021