

RECEIVED

Revised original attached

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL, PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

MAR 6 1987

00231

BUREAU OF RATES

DEPARTMENT FILE NO. 00231
INSURER'S CLAIM NO. 508N-1071

1. PRIMARY INSURER NAME: St Paul Fire & Marine Ins. INSURER CODE: 1607
(See Table A)

2. EXCESS INSURER NAME: N A INSURER CODE: _____
(See Table A)

3. INSURED'S NAME: FREIER, EUGENE H.
(Last Name, First and Middle Name)

STREET ADDRESS: PO Box 185
CITY, STATE: Port Orange, FL ZIP: 32029 COUNTY CODE: 08
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>508N-1071</u>	<u>\$1,000,000.00</u>	<u>\$3,000,000.00</u>
EXCESS INSURER :	_____	\$ _____	\$ _____

5. Is the insured physician a Foreign Medical Graduate? If yes, enter the country in which primary medical education was received:
 (01) Yes
 (02) No

6. PROFESSION OR BUSINESS: (Check one)
 (01) Physicians & Surgeons
 (02) Hospitals
 (03) Podiatrists
 (04) Other Medical Professionals
 (05) Clinics
 (06) Ambulatory Surgical Centers
 (07) Other Health Care Facilities

7. SPECIALTY CODE: S.O.1.02 (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)
(See Table C)

8. BOARD CERTIFICATION: (Check one)
 (01) In specialty coded in Item 7, above.
 (02) In a different specialty.
 (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____
 (04) Insured is not board certified. (Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
 (01) Hospital Inpatient Facility
 (02) Emergency Room
 (03) Hospital Outpatient Facility
 (04) Nursing Home
 (05) Physician's Office
 (06) Patient's Home
 (07) Other Outpatient Facility
 (08) Other Location
 (09) 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: Delgado Hospital INSTITUTION CODE: 100015
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)
 (01) Patient's Room
 (02) Operating Suite
 (03) Recovery Room
 (04) St. Paul Fire and Marine Insurance Company & Delivery Room
 (05) Physical Therapy Dept.
 (06) Nursery
 (07) Critical Care Unit
 (08) Special Procedure Room
 (09) Radiology
 (10) Emergency Room

Corrected

DEC 9 1987

RODGER WILEY
CLAIMS TECHNICIAN
FLORIDA SERVICE CENTER

FLORIDA DEPARTMENT OF INSURANCE
 FLORIDA MEDICAL PROFESSIONAL LIABILITY
 INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
 INSURER'S CLAIM NO. 50811071
08-350

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 9,999 .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ NA .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 5330 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 1059 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- _____ day
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- _____ day
36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
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? ___ (01) Yes ___ (02) 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: _____ ADDRESS _____
 TELEPHONE: (_____) _____