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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

8700047

BUREAU OF RATES

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____
509JL5787 09C 001

1. PRIMARY INSURER NAME: St. Paul Fire + Marine INSURER CODE: 01473
(See Table A)
2. EXCESS INSURER NAME: _____ INSURER CODE: _____
(See Table A)
3. INSURED'S NAME: Kayan, Sabih MD.
(Last Name, First and Middle Name)
- STREET ADDRESS: P.O. Box 271988
- CITY, STATE: Tampa, Fla. ZIP: 33688 COUNTY CODE: 03
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509JL5787</u>	<u>\$ 1,000,000.00</u>	<u>\$ 1,000,000.00</u>
EXCESS INSURER :	_____	\$ _____	\$ _____

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

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

7. SPECIALTY CODE: 8.024.9 (Applies to physicians, surgeons, and other health care professionals.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

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 (04) Nursing Home (07) Other Outpatient Facility
 (02) Emergency Room (05) Physician's Office (08) Other Location
 (03) Hospital Outpatient Facility (06) Patient's Home (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: HUMAN Development Center of

11. NAME OF INSTITUTION: Pasco County INSTITUTION CODE: N/A
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)
- (01) Patient's Room (04) Labor & Delivery Room (07) Critical Care Unit
 (02) Operating Suite (05) Physical Therapy Dept. (08) Special Procedure Room
 (03) Recovery Room (06) Nursery (09) Radiology
 (10) Emergency Room
- N/A

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13. DATE OF OCCURRENCE: 07/20/82

DATE REPORTED TO INSURER: 10/26/84

14. INJURED PERSON'S AGE: 61 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: M (Circle one)

14.1 INJURED PERSON'S NAME:

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

Depression with psychotic features

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

N/A

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.

Chant. alleged improper prescription of medication

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.

Prescribed anti depression drugs

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.

Bladder problems

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

- (01) Emotional only - Fright, no physical damage.
- (02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
- Temp- (03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
- orary (04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
- (05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
- Perma- (06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
- nent (07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
- (08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
- (09) Death

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21. DATE OF SUIT, IF ANY: 10/15/84

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

DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1) <u>Ronald KNAUS, D.O.</u>	<u>unknown</u>	<u>unknown</u>
2) <u>John R. KOZEK, D.O.</u>	"	"
3) <u>IRA H. LISS, M.D.</u>	"	"
4) <u>Human Development Center</u>	"	"
5) _____	"	"

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)
 (01) Yes ___ (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 01/07/87

25. FINAL METHOD OF CLAIM DISPOSITION:
 (01) Settled by parties.
 ___ (02) Disposed of by a court.
 ___ (03) Disposed of by arbitration.

26. SETTLEMENT: (Check one)

- ___ (01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
- ___ (02) After arbitration is initiated or prior to suit being filed.
- ___ (03) Within 90 days of suit being filed.
- (04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
- ___ (05) Prior to completion of the swearing of the jury.
- ___ (06) Prior to filing of the notice of appeal.
- ___ (07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
- ___ (08) During appeal.
- ___ (09) After appeal.
- ___ (10) Claim or suit abandoned.

27. COURT: (Check one)

- (01) No court proceedings.
- ___ (02) Directed verdict for plaintiff.
- ___ (03) Directed verdict for defendant.
- ___ (04) Judgment notwithstanding the verdict for the plaintiff.
- ___ (05) Judgment notwithstanding the verdict for the defendant.
- ___ (06) Judgment for the plaintiff.
- ___ (07) Judgment for the defendant.
- ___ (08) Judgment for the plaintiff after appeal.
- ___ (09) Judgment for the defendant after appeal.
- ___ (10) Other.
- ___ (11) Summary judgment for the plaintiff.
- ___ (12) Summary judgment for the defendant.

28. ARBITRATION: (Check one)

- (01) Claim not subject to arbitration.
- ___ (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
- ___ (03) Award for plaintiff.
- ___ (04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)
 ___ (01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - \$ 0 .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - \$ 0 .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - - - - - \$ 8583 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 1434 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - 0 day
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - 0 day
36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - \$ 0 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE - - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</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 - - - - - \$ 0 .00
- B) COST TO THE INSURER OF THE PAYMENTS - - - - - \$ 0 .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - \$ 0 .00
- D) DID YOU PURCHASE AN ANNUITY? (01) Yes (02) No

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

N/A

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

N/A
Chmt. Voluntarily dismissed case

CONTACT PERSON: R. L. FAGLEY ADDRESS P.O. Box 22826
 TELEPHONE: (813) 879 6154 TAMPA, FLA. 33622