

POST MARKED

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

8901949
DEPT. FILE NO.

JUN 5 1989

INSURER'S CLAIM NUMBER: 58-253604

BUREAU OF RATES

1. PRIMARY INSURER NAME: CONTINENTAL CASUALTY CO. INSURER CODE: 09165
(See Table A)
2. EXCESS INSURER NAME: NONE INSURER CODE:
(See Table A)
- 3a. HEALTH CARE PROVIDER: GUPTA, SHOBHA ~~(M.D.)~~
(Last Name, First and Middle Name or Hospital Name from Table D)
- 3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0036479
- 3c. INSURED'S NAME: SAME
- STREET ADDRESS: 333 N.W. 70 AVE. #112
- CITY: PLANTATION STATE: FL ZIP: 33317 COUNTY CODE: 10
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>PSC4817500</u>	<u>\$1,000,000.00</u>	<u>\$1,000,000.00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$.00</u>	<u>\$.00</u>

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? (01) Yes (02) No (If yes, enter the country in which primary medical education was received: INDIA) IN

6. PROFESSION OR BUSINESS: (Check one)
- | | | |
|--|---|---|
| <input checked="" type="checkbox"/> (01) Physicians & Surgeons | <input type="checkbox"/> (04) Dentist | <input type="checkbox"/> (07) Crisis Stabilization Unit |
| <input type="checkbox"/> (02) Hospitals | <input type="checkbox"/> (05) Abortion Clinics | <input type="checkbox"/> (08) Health Maintenance Organization |
| <input type="checkbox"/> (03) Podiatrists | <input type="checkbox"/> (06) Ambulatory Surgical Centers | |

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and dentists. 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. Enter the additional specialty code here: _____
- (04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> (01) Hospital Inpatient Facility | <input type="checkbox"/> (04) Nursing Home | <input type="checkbox"/> (07) Other Outpatient Facility |
| <input type="checkbox"/> (02) Emergency Room | <input type="checkbox"/> (05) Physician's Office | <input type="checkbox"/> (08) Other Location |
| <input type="checkbox"/> (03) Hospital Outpatient Facility | <input type="checkbox"/> (06) Patient's Home | <input type="checkbox"/> (09) Other Hospital/Institution |

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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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

21. DATE OF SUIT, IF ANY: 1, 22, 88

21.1 CIRCUIT COURT CASE NUMBER: 88-01768

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 10 (SEE TABLE B)

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>FERNANDEZ, HILAIRE</u>	<u>44050</u>	<u>UNK.</u>
2)	<u>FLA. PATIENTS COMPENSATION FUND</u>	<u>46010</u>	<u>UNK.</u>
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 04, 13, 89

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

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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 filed and prior to or during the course of mandatory settlement conference.
- (05) During trial but before court verdict.
- (06) After court verdict and prior to filing of notice of appeal.
- (07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claim or suit abandoned.

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27. COURT: (Check one)
- | | |
|---|--|
| <input checked="" type="checkbox"/> (01) No court proceedings. | <input type="checkbox"/> (07) Judgment for the defendant. |
| <input type="checkbox"/> (02) Directed verdict for plaintiff. | <input type="checkbox"/> (08) Judgment for the plaintiff after appeal. |
| <input type="checkbox"/> (03) Directed verdict for defendant. | <input type="checkbox"/> (09) Judgment for the defendant after appeal. |
| <input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff. | <input type="checkbox"/> (10) Other |
| <input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant. | <input type="checkbox"/> (11) Summary judgment for the plaintiff. |
| <input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (12) Summary judgment for the defendant. |

28. ARBITRATION: (Check one)
- | | |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration. | <input type="checkbox"/> (03) Award for plaintiff. |
| <input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (04) Award for defendant. |

29. Was there an itemized verdict? (Check one)
- (01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - \$ 50,000 .00
- 30.1 AMOUNT OF DEDUCTIBLE PAID BY 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: - - - - - \$ 29252 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 24282 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - 0 days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - 0 days
36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - \$ 0 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - - -	\$ ^{EST.} <u>12,000</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: - - - - - \$ 50,000 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- | | |
|--|-------------------|
| A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - - | \$ <u>N/A</u> .00 |
| B) COST TO THE INSURER OF THE PAYMENTS - - - - - | \$ <u>N/A</u> .00 |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - | \$ <u>N/A</u> .00 |
- D) DID YOU PURCHASE AN ANNUITY? (01) Yes (02) No

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

_____ N/A _____

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one)

- (01) No limit (neither party requests or agrees to voluntary binding arbitration).
- (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
- (03) \$250,000 limit (both parties accept arbitration). (See Item 42 for exception.)
- (04) \$350,000 limit (plaintiff rejects arbitration).
- (05) Does not apply because occurrence happened before the 02-08-88 law.

42. IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMIC DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: - - - - - \$ N/A .00

43. COLLATERAL SOURCE INFORMATION:

ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

- A. 50% Health
- B. ___% Disability
- C. ___% Workers' Compensation
- D. ___% Automobile
- E. 50% Medicare, Medicaid & Social Security
- F. ___% Other sources, specify: _____

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

_____ N/A _____

CONTACT PERSON: MARSHA Y. BANFIELD ADDRESS 8151 W. BROWARD BLVD.
TELEPHONE: (305) 370-2404 PLANTATION FL 33324