

POST MARKED

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

8900204

DEPT. FILE NO.

JAN 17 1989

BUREAU OF RATES INSURER'S CLAIM NUMBER: 509JL 0964-090001

1. PRIMARY INSURER NAME: ST PAUL INSURER CODE: 01470  
(See Table A)

2. EXCESS INSURER NAME: NA INSURER CODE: ---  
(See Table A)  
NMI

3a. HEALTH CARE PROVIDER: FORIZS, LORANT  
(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: 00016521

3c. INSURED'S NAME: SAME

STREET ADDRESS: 983 Sunrise Drive

CITY: Tarpon Springs STATE: FL ZIP: 34689 COUNTY CODE: 04  
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509JL0964</u>	<u>\$250,000.00</u>	<u>\$750,000.00</u>
EXCESS INSURER:	<u>NA</u>	<u>\$ 0.00</u>	<u>\$ 0.00</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: HUNGARY HU)

6. PROFESSION OR BUSINESS: (Check one)  
 (01) Physicians & Surgeons    \_\_\_ (04) Dentist    \_\_\_ (07) Crisis Stabilization Unit  
\_\_\_ (02) Hospitals    \_\_\_ (05) Abortion Clinics    \_\_\_ (08) Health Maintenance  
\_\_\_ (03) Podiatrists    \_\_\_ (06) Ambulatory Surgical Centers    Organization

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and dentists.  
(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. Enter the additional specialty code here: \_\_\_\_\_  
\_\_\_ (04) Insured is not board certified. (See 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 PLAC. OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY  
OCCURRED: NA

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11. NAME OF INSTITUTION: HORIZON HOSPITAL INSTITUTION CODE: 104017  
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)  
 (01) Patient's Room                       (05) Physical Therapy Dept.                       (09) Radiology  
 (02) Operating Suite                       (06) Nursery                       (10) Emergency Room  
 (03) Recovery Room                       (07) Critical Care Unit                       (11) Other \_\_\_\_\_  
 (04) Labor & Delivery Room                       (08) Special Procedure Room

13. DATE OF OCCURRENCE: 08/28/86

DATE REPORTED TO INSURER: 04/07/88

14. INJURED PERSON'S AGE: 31 Years (if less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: M  F (Circle one)

14.1 INJURED PERSON'S NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: \_\_\_\_\_ (LEAVE BLANK)  
15.

NA

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

PATIENT COMMITTED SUICIDE

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

CLAIMANT FAMILY ALLEGED INSURED DID NOT PROPERLY TREAT CLAIMANT

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.

NA

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.

PATIENT COMMITTED SUICIDE WHILE AT PSYCHIATRIC HOSPITAL.

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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 delaye
- (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: NA

21.1 CIRCUIT COURT CASE NUMBER: NA

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: NA (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)	_____	_____	_____
2)	<u>NONE</u>	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 01, 10, 89

25. FINAL METHOD OF CLAIM DISPOSITION:  
 (01) Settled by parties. CLAIM NOT MADE  
 (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: ----- \$ 0.00

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: ----- \$ 0.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 0.00

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:

	<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 -----   | \$ <u>0</u> .00 |
| B) COST TO THE INSURER OF THE PAYMENTS -----  | \$ <u>0</u> .00 |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF -----  | \$ <u>0</u> .00 |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" type="checkbox"/> (02) No |                 |

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ NIA \_\_\_\_\_  
\_\_\_\_\_

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: - - - - - \$ 0 .00

43. COLLATERAL SOURCE INFORMATION:

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

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

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ NONE RECOMMENDED \_\_\_\_\_  
\_\_\_\_\_

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