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FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

9402407

DEPT. FILE NO.

BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 2386

1. PRIMARY INSURER NAME: Frontier Insurance Company INSURER CODE: 09574
(See Table A)

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

3a. HEALTH CARE PROVIDER: Ruiz, Roberto De Jesus
(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: 0012436
~~11213111~~

3c. INSURED'S NAME: Roberto Ruiz, MD

STREET ADDRESS: 9735 East Fern Street

CITY: Miami STATE: FL ZIP: 33157 COUNTY CODE: 011
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>RRM001087</u>	<u>\$ 500,000 .00</u>	<u>\$ 1,500,000 .00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ N/A .00</u>	<u>\$ N/A .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: Spain)

SP

6. PROFESSION OR BUSINESS: (Check one)

- (01) Physicians & Surgeons
- (02) Hospitals
- (03) Podiatrists
- (04) Dentist
- (05) Abortion Clinics
- (06) Ambulatory Surgical Centers
- (07) Crisis Stabilization Unit
- (08) Health Maintenance Organization

7. SPECIALTY CODE: 8,0,2,4,9 (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
- (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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: n/a INSTITUTION CODE: n/a (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 n/a
 (04) Labor & Delivery Room (08) Special Procedure Room

13. DATE OF OCCURRENCE: 02/04/93

DATE REPORTED TO INSURER: 05/12/93

14. INJURED PERSON'S AGE: 41 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: Drug addiction (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: None. 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Patient died due to multiple drug intoxication. 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: Patient was given Methadone over a period of time for detoxification from drug use. 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: Death 19.

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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

DATE OF SUIT, IF ANY: 1/11/11

- 1 CIRCUIT COURT CASE NUMBER: 93-13317 CA 12
- 2 COUNTY CODE OF COUNTY SUIT FILED IN: 11/11 (SEE TABLE B)

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>Comprehensive Psychiatric</u>	<u>n/a</u>	<u>n/a</u>
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

DATE OF FINAL CLAIM DISPOSITION: 3/10/11

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

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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7. COURT: (Check one)
- (01) No court proceedings.
 - (02) Directed verdict for plaintiff.
 - (03) Directed verdict for defendant.
 - (04) Judgment notwithstanding the verdict for plaintiff.
 - (05) Judgment notwithstanding the verdict for 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.

8. ARBITRATION: (Check one)
- (01) Claim not subject to arbitration.
 - (02) Claim subject to arbitration, but settlement reached in lieu of award.
 - (03) Award for plaintiff.
 - (04) Award for defendant.

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

10. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 00.00
- 10.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: ----- \$ 00.00
11. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 00.00
12. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 1380.00
13. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 816.00
14. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- 0 days
15. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- 0 days
16. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ 0.00

17. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

18. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 0.00

19. 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

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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: ----- \$ 0 .00

43. COLLATERAL SOURCE INFORMATION:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. <input type="checkbox"/> % Health	D. <input type="checkbox"/> % Automobile
B. <input type="checkbox"/> % Disability	E. <input type="checkbox"/> % Medicare, Medicaid & Social Security
C. <input type="checkbox"/> % Workers' Compensation	F. <input type="checkbox"/> % Other sources, specify: <u>n/a</u>

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

Risk Management

CONTACT PERSON: Patricia Schmidt ADDRESS Rock Hill, N.Y. 12775-8000
TELEPHONE: (914) 796-2300