



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

9600135

DEPT. FILE NO.

JAN 16 1996

INSURER'S CLAIM NUMBER: 00-001173

BUREAU OF PROPERTY &
 CASUALTY FORMS & RATES

1. PRIMARY INSURER NAME: TRUCK INSURANCE EXCHANGE INSURER CODE: 04335
 (See Table A)

2. EXCESS INSURER NAME: LLOYDS OF LONDON INSURER CODE: 46060
 (See Table A)

3a. HEALTH CARE PROVIDER: TOLEDO, VELIA M.
 (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: 0028728

3c. INSURED'S NAME: CAC - RAMSAY HEALTH PLANS INC.

STREET ADDRESS: 2850 DOUGLAS ROAD

CITY: CORAL GABLES STATE: FL ZIP: 33134 COUNTY CODE: 01

(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>011770090000</u>	<u>\$ 500,000.00</u>	<u>\$ 0 .00</u>
	<u>C30042</u>	<u>1.5 mil</u>	
EXCESS INSURER:	<u>C30043</u>	<u>\$ 3.0 MIL .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: SPAIN)

SP

6. PROFESSION OR BUSINESS: (Check one)

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

7. SPECIALTY CODE: 810251 (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. ^{N/A} IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: _____

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

12. N/A LOCATION OF INSTITUTIONAL INJURY: (Check one)

<input type="checkbox"/> (01) Patient's Room	<input type="checkbox"/> (05) Physical Therapy Dept.	<input type="checkbox"/> (09) Radiology
<input type="checkbox"/> (02) Operating Suite	<input type="checkbox"/> (06) Nursery	<input type="checkbox"/> (10) Emergency Room
<input type="checkbox"/> (03) Recovery Room	<input type="checkbox"/> (07) Critical Care Unit	<input type="checkbox"/> (11) Other _____
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 07/09/92
DATE REPORTED TO INSURER: 05/21/93

14. INJURED PERSON'S AGE: 71 Years (If less than one year, enter 00; if unknown, enter UNK.)
INJURED PERSON'S SEX: M F (Circle one)

15. INJURED PERSON'S NAME:
STREET ADDRESS
CITY:

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
GASTRITIS WITH PLAN TO RULE OUT HEMORRHAGIC GASTRITIS AND MEDICATION INDUCED GASTRITIS - 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
PATIENT EXPIRED AS A RESULT OF "HYPOVOLEMIC SHOCK DUE TO SEPSIS," INTRAABDOMINAL CATASTROPHE, AND RENAL FAILURE. 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
NOTICE OF INTENT TO INITIATE LITIGATION FOR MEDICAL MALPRACTICE. 17.

18. N/A 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.

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 CAUSED BY DELAY IN TREATMENT OF SEPSIS RESULTING IN ORGAN FAILURE. 19.

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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: 04/08/94

21.1 CIRCUIT COURT CASE NUMBER: 94 06302

1.2 COUNTY CODE OF COUNTY SUIT FILED IN: 1011 (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>BRITO, JORGE</u>	<u>04335</u>	<u>00-00173</u>
2) <u>HUECK, ALAN</u>	<u>04335</u>	<u>00-00173</u>
3) <u>KOZOLCHYK, SAUL</u>	<u>04335</u>	<u>00-00173</u>
4) <u>SEPULVEA, SEBASTIAN</u>	<u>04335</u>	<u>00-00173</u>
5) _____		

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)

- (01) Yes (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 11/28/95

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)
- (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.

28. 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.

29. ^{N/A} 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: ----- \$ 300,000.00

0.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: ----- \$ 100,000.00

31. ^{N/A} INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 0.00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 27,328.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 6,507.00

34. ^{N/A} NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- 0 days

35. ^{N/A} ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- 0 days

36. ^{N/A} INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ 0.00

37. ^{N/A} INJURED PERSON'S

TOTAL ECONOMIC LOSS:	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - - \$	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
B) ESTIMATED FUTURE - - - - \$	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 300,000.00

39. ^{N/A} 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. ^{N/A} BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: _____

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

43. ^{N/A} COLLATERAL SOURCE INFORMATION:

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

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

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

CONTACT PERSON: FRED B. GILLET ADDRESS: P.O. Box 4999
TELEPHONE: (213) 964-8271 LOS ANGELES, CA 90051-4999