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

9701148

DEPT. FILE NO.

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 94-21296-01-047

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 4 | 4 | 0 | 5 | 0
(See Table A)

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

3a. HEALTH CARE PROVIDER: REINA, LUIS ANDRES
(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: 0 | 0 | 4 | 6 | 5 | 6 | 0 |

3c. INSURED'S NAME: LUIS A. REINA, MD

STREET ADDRESS: SUITE 515, 7100 WEST 20 AVENUE

CITY: HIALEAH STATE: F | L ZIP: 3 | 3 | 0 | 1 | 6 COUNTY CODE: 0 | 1
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>1001571</u>	\$ <u>250,000.00</u>	\$ <u>750,000.00</u>
EXCESS INSURER:	<u>N/A</u>	\$ <u>0.00</u>	\$ <u>0.00</u>

4. 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

5. 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

6. SPECIALTY CODE: 8 | 0 | 2 | 6 | 1 | (Applies to physicians, surgeons, and dentists.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

7. 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)

8. 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

9. 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. NAME OF INSTITUTION: HIALEAH HOSPITAL INSTITUTION CODE: 1 | 0 | 0 | 0 | 5 | 3
 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

<input checked="" 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: 05/29/92
 DATE REPORTED TO INSURER: 07/08/94

14. INJURED PERSON'S AGE: 60 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON
 14.1 INJURED PERSON
 STREET _____
 CITY: MIAMI STATE: F | L ZIP: 3 | 3 | 1 | 3 | 3

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>Consultation for numbness and weakness in left leg.</u>	(LEAVE BLANK) 15.
6. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>N/A</u>	16.
7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>Following aortoiliac enderectomy and subsequent surgery embolectomy, patient require mid thigh amputation of the left leg, allegedly as a result of improper assessment of postoperative status by Dr. Reina. Expert witnesses were divided regarding the appropriateness of Dr. Reina's care and the cause of the amputation.</u>	17.
8. 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: <u>N/A</u>	18.
9. 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: <u>Mid thigh amputation of left leg with multiple revisions and ongoing antibiotic therapy.</u>	19.

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27. COURT: (Check One)

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

<input checked="" type="checkbox"/> (01) Claim not subject to arbitration. <input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award.	<input type="checkbox"/> (03) Award for plaintiff. <input type="checkbox"/> (04) Award for defendant.
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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: \$ 250,000.00

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: \$ 27,677.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: \$ 49,321.00

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>0.00</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: \$ 250,000.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS	\$ <u>0.00</u>
B) COST TO THE INSURER OF THE PAYMENTS	\$ <u>0.00</u>
C) TOTAL EXPECTED PAYMENT TO PLAINTIFF	\$ <u>0.00</u>

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-ECONOMICAL 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. 0% Health
- B. 0% Disability
- C. 0% Worker's Compensation
- D. 0% Automobile
- E. 0% Medicare, Medicaid & Social Security
- F. 0% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured met with experts and insurance company personnel.

CONTACT PERSON: Fred Scheriff, Miami Regional Claims Manager ADDRESS: Physicians Protective Trust Fund
TELEPHONE: (305) 442-4001 2121 Ponce De Leon Boulevard, Suite 350
Coral Gables, Florida 33134