

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

9700176

DEPT. FILE NO.

JAN 28 1987

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: A95-16430-93

1. PRIMARY INSURER NAME: Florida Physicians Insurance Company INSURER CODE: 1019151813
(See Table A)
2. EXCESS INSURER NAME: NONE INSURER CODE: N.A.
(See Table A)

3a. HEALTH CARE PROVIDER: BISKUP-VERAS, TERESA 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: 0,03,1,7,23

3c. INSURED'S NAME: SAME

STREET ADDRESS: 5015 MANATEE AVENUE, WEST

CITY: BRADENTON STATE: FL ZIP: 33529 COUNTY CODE: 15
(See Table B)

| | POLICY NUMBER | PER CLAIM POLICY LIMITS | AGGREGATE POLICY LIMITS |
|------------------|---------------|-------------------------|-------------------------|
| PRIMARY INSURER: | <u>6836</u> | <u>\$250,000.00</u> | <u>\$ 750,000 .00</u> |
| EXCESS INSURER: | <u>NONE</u> | <u>\$ N.A. .00</u> | <u>\$ N.A. .00</u> |

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

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: 802,49
(See Table C) (Applies to physicians, surgeons, and dentists.
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)
- | | | |
|--|---|--|
| <input 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 checked="" 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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11. NAME OF INSTITUTION: N.A. INSTITUTION CODE: N.A. (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one) N.A.
 (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: 04/12/93
DATE REPORTED TO INSURER: 04/10/95

14. INJURED PERSON'S AGE: 68 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: Paranoia and stage III dementia. (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: Claimant developed phenothiazine-induced extra pyramidal syndrome 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: Prescription of Haldol. 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: Temporary phenothiazine-induced extra pyramidal syndrome. 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: 11/14/95

21.1 CIRCUIT COURT CASE NUMBER: CA-95-003593

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 15 (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>Gardner, Susan</u> | <u>09583</u> | <u>A95-16430-93</u> |
| 2) | _____ | _____ | _____ |
| 3) | _____ | _____ | _____ |
| 4) | _____ | _____ | _____ |
| 5) | _____ | _____ | _____ |

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

24. DATE OF FINAL CLAIM DISPOSITION: 11/26/96

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: ----- \$ 45,000.00

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: ----- \$ 4232.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 2618.00

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>UNK</u> .00 | \$ <u>0</u> .00 | \$ <u>UNK</u> .00 |
| B) ESTIMATED FUTURE | \$ <u>UNK</u> .00 | \$ <u>0</u> .00 | \$ <u>UNK</u> .00 |

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 45,000.00

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

- | | |
|---|--------------------|
| 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? <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: 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. UNK% Health
- B. 0% Disability
- C. 0% Workers' Compensation
- D. 0% Automobile
- E. UNK% Medicare, Medicaid & Social Security
- F. UNK% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: This complication is a known risk of treatment with anti-psychotic medications

JAMES W. SCHELFHAUDT

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