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

9700216

DEPT. FILE NO.

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 96M06182

1. PRIMARY INSURER NAME: Frontier Insurance Company of New York INSURER CODE: 0,9,5,7,4
(See Table A)

2. EXCESS INSURER NAME: n/a INSURER CODE: 1,1,1,1,1
(See Table A)

3a. HEALTH CARE PROVIDER: Shah, Mahendra B.
(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: 0,0,5,6,8,5,7

3c. INSURED'S NAME: Mahendra Shah, M.D.

STREET ADDRESS: 377 Mainland Ave., Suite 203

CITY: Altamonte Springs STATE: FL ZIP: 3,2,7,0,1 COUNTY CODE: 1,7
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>R-CM-0500396-4</u>	<u>\$ 250,000 .00</u>	<u>\$ 750,000 .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: India IN)

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: 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 (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 PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY
OCCURRED: The homicide occurred in a neighbor's home.

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27. COURT: (Check one) n/a

<input 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) Judgment notwithstanding the verdict for plaintiff. <input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant. <input type="checkbox"/> (06) Judgment for the plaintiff.	<input type="checkbox"/> (07) Judgment for the defendant. <input type="checkbox"/> (08) Judgment for the plaintiff after appeal. <input type="checkbox"/> (09) Judgment for the defendant after appeal. <input type="checkbox"/> (10) Other <input type="checkbox"/> (11) Summary judgment for the plaintiff. <input type="checkbox"/> (12) Summary judgment for the defendant.
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28. ARBITRATION: (Check one) n/a

<input 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) n/a

(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: ----- \$ 338 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 25 .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: n/a

A) PRESENT VALUE OF PERIODIC PAYMENTS -----	\$ <u> </u> .00
B) COST TO THE INSURER OF THE PAYMENTS -----	\$ <u> </u> .00
C) TOTAL EXPECTED PAYMENT TO PLAINTIFF -----	\$ <u> </u> .00
D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input 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) n/a
 (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: n/a
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: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured discussed case with defense counsel and insurance personnel.

CONTACT PERSON: *Leslie Ann Johnson*
TELEPHONE: (407) 648-9028

ADDRESS Frontier Insurance Company of N.Y.
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Orlando, FL 32801