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

9702340

OCT 6 1997

DEPT. FILE NO.

BUREAU OF PROPERTY
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 96M05828

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: _____
(See Table A)

3a. HEALTH CARE PROVIDER: Cole, James Webb III
(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: 0,0,5,5,0,8,5

3c. INSURED'S NAME: James W. Cole, M.D.

STREET ADDRESS: Heritage Hospital -- Post Office Box 640550

CITY: Beverly Hills, STATE: F, L, ZIP: 3,4,4,6,4 COUNTY CODE: 4,7
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>F-KM-0009378-5/001</u>	<u>1 Million .00</u>	<u>\$ 3 Million .00</u>
EXCESS INSURER:	<u>n/a</u>	<u>\$.00</u>	<u>\$.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: _____)

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: 80420
___ (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: Patient was involved in a motor vehicle accident in the town of Crystal River, FL

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11. NAME OF INSTITUTION: n/a INSTITUTION CODE:
 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one) n/a

<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: 11 / 14 / 95
 DATE REPORTED TO INSURER: 05 / 10 / 96

14. INJURED PERSON'S AGE: 48 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:
<u>Schizophrenia and drug and alcohol dependency</u> | (LEAVE BLANK)
15. |
| 16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
<u>N/A</u> | 16. |
| 17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
<u>On the evening of the date that the patient was discharged from the hospital, he was involved in a motor vehicle accident resulting in quadriplegia and he subsequently died from complications of same. His Estate alleged negligent supervision and follow up resulting in death.</u> | 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:
<u>Please see Response No. 17.</u> | 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:
<u>Death</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) 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. |
|---|--|

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. |
|---|--|

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: - - - - - \$ 1,686 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 1,371 .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>0</u> .00 |
| B) COST TO THE INSURER OF THE PAYMENTS - - - - - | \$ <u>0</u> .00 |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - | \$ <u>0</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. % 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 OCCURRENCES LESS LIKELY: Insured discussed case with defense counsel and insurance personnel.

CONTACT PERSON: Carol Ann Lopez ADDRESS Frontier Insurance Company of
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