



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

11. NAME OF INSTITUTION: MORTON F PLANT HOSPITAL INSTITUTION CODE: 1 | 0 | 0 | 1 | 2 | 7 |  
 (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: 07/10/94  
 DATE REPORTED TO INSURER: 06/13/95

14. INJURED PERSON'S AGE: 34 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>Colloid cyst.</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>Patient was hospitalized for evaluation of severe headaches. A CT scan indicated a questionable cyst in the third ventricle. Following a diagnostic MRI, the patient arrested and expired.</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>Patient was being evaluated for severe headaches with a CT and MRI.</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>Patient arrested and expired.</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: . . . . . \$ 480,000.00

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: . . . . . \$ 39,293.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: . . . . . \$ 22,090.00

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: . . . . . \$ 480,000.00

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: N/A

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

- |                                     |  |
|-------------------------------------|--|
| A. <u>0</u> % Health                | D. <u>0</u> % Automobile                           |
| B. <u>0</u> % Disability            | E. <u>0</u> % Medicare, Medicaid & Social Security |
| C. <u>0</u> % Worker's Compensation | F. <u>0</u> % Other sources, specify: _____        |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Insured has discussed case with insurance company personnel, medical experts and defense counsel.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONTACT PERSON: Beth Rominger  
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