

FLORIDA DEPARTMENT OF INSURANCE  
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

509 ML 0163  
FILE# 093001

46030  
PRIMARY CARRIER  
Company Code  (Florida Certificate of Authority Number)

84 00018

Company Name The St. Paul Insurance Companies (FMMJUA)

Policy Number 509MC0163

EXCESS CARRIER  
Company Code  (Florida Certificate of Authority Number)

Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Calendar Year Claim Closed  84 FCC  M  M  I IAC  3

Insured DR. ALBERTO MARTINEZ-AZAY

County Code  
 01

Address 350 S.W. 27th AVE., MIRMI, FL.

(1) Speciality G.P. Code  06

(2) Date of Incident (Month, Day, Year)  09  07  79

(3) Date submitted for mediation (Month, Day, Year)

(4) Disposition of mediation (check one):  
(1)  Plaintiff (2)  Defendant (3)  No final conclusion

(5) Date of suit, if filed (Month, Day, Year)  09  26  87

(6) Disposition of incident (check one):  
(1)  Final Judgment (2)  Settlement  
(3)  Final Disposition Not Resulting in Payment on Behalf of the Insured

(7) Date and amount of Judgment or Settlement (Month, Day, Year)  03  07  84

A. Primary Indemnity \$ 40,000. C. Excess Indemnity \$ \_\_\_\_\_  
B. Primary Defense \$ 12,826. D. Excess Defense Costs \$ \_\_\_\_\_

(8) Summary Judgment (1)  For Plaintiff (2)  For Defendant

(9) Directed Verdict (1)  For Plaintiff (2)  For Defendant

(10) Trial (1)  YES (2)  NO

(11) Date and reason for final disposition, if no settlement or judgment:  
(Month, Day, Year)

(12) Include brief summary of occurrence which created claim on back.

Client alleged improper care and tx during hospitalization caused amputation of left foot.