

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

8903129

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 509 JH 8471 09J 301

1. PRIMARY INSURER NAME: ST. PAUL F. + M. INSURER CODE: 01470
(See Table A)

2. EXCESS INSURER NAME: 0 INSURER CODE: _____
(See Table A)

3a. HEALTH CARE PROVIDER: MOORE, JULIUS DAVID
(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: 0021858

3c. INSURED'S NAME: SAME

STREET ADDRESS: 1823 BUFORD CT.

CITY: TALLAHASSEE STATE: FL ZIP: 32308 COUNTY CODE: 13
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509 JH 8471</u>	<u>\$ 1 MIL .00</u>	<u>\$ 3 MIL .00</u>
EXCESS INSURER:	<u>0</u>	<u>\$ 0 .00</u>	<u>\$ 0 .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)

<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: 8,0,2,4,9
(See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check one)

<input checked="" type="checkbox"/> (01) In specialty coded in Item 7, above.	
<input type="checkbox"/> (02) In a different specialty.	
<input type="checkbox"/> (03) In the specialty in Item 7 and another. Enter the additional specialty code here: _____	
<input type="checkbox"/> (04) Insured is not board certified.	(See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)

<input checked="" 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 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: NA

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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 dela
- (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: 2, 19, 87

21.1 CIRCUIT COURT CASE NUMBER: 87-515

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 13 (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)	TALLAHASSEE MEN. REG. MED. CTR	UNK	UNK
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 9, 20, 89

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 conferenc
- (05) Dur 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 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 checked="" type="checkbox"/> (10) Other VOL. DISMISSAL |
| <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: ----- \$ 9999 .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: ----- \$ 54,844 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 5860 .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:	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE	\$ _____ .00	\$ _____ .00	\$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 9999 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- | | |
|--|-----------------------|
| 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? (01) Yes (02) No

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: NA

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: ----- \$ NA .00

43. COLLATERAL SOURCE INFORMATION:

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

- UNK
- | | |
|---|--|
| 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: UNK

ST-PAUL FIRE & MARINE INS. CO.
ORLANDO SERVICE CENTER
1060 MAITLAND CENTER COMMONS BLVD.
MAITLAND, FLORIDA 32751

CONTACT PERSON: Roger M. Wiley ADDRESS _____
TELEPHONE: 407-660-2700