



NOV 18 1992

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

9201895

DEPT. FILE NO.

BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 88-0358-10A

1. PRIMARY INSURER NAME: Legion Insurance Co INSURER CODE: 09387
(See Table A)

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

3a. HEALTH CARE PROVIDER: Hughes, Michael Clement
(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: 0027456

3c. INSURED'S NAME: Michael Hughes
STREET ADDRESS: Bayview Plaza 322 Aviation Ave, #303
CITY: Coconut Grove STATE: FL ZIP: 33133 COUNTY CODE: 01
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>02300001</u>	<u>\$ 1,000,000 .00</u>	<u>\$ 3,000,000 .00</u>
EXCESS INSURER:	_____	<u>\$ _____ .00</u>	<u>\$ _____ .00</u>

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? ___ (01) Yes X (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 Organization
___ (03) Podiatrists ___ (06) Ambulatory Surgical Centers

7. SPECIALTY CODE: 80249
(See Table C) (Applies to physicians, surgeons, and dentists. 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: NA

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11. NAME OF INSTITUTION: Charter Hospital of Miami INSTITUTION CODE: 110011
 (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: 2/14/89
 DATE REPORTED TO INSURER: 2/26/91

14. INJURED PERSON'S AGE: 19 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: _____ First and Middle Initial _____
 CITY: _____ STATE: _____ ZIP: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Schizophrenic, catatonic (LEAVE BLANK)
 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NA
 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Patient Alleges mis diagnosis of non-tropical sprue
 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: Patient alleges mis diagnosis of condition of non-tropical sprue
 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: alleges misdiagnosis
 19.

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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 delaye
- (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: 7.19.91

21.1 CIRCUIT COURT CASE NUMBER: 91-32618 CA16

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 04 (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 NO.
1) <u>Rene Ruiz - Esst</u>	<u>unk</u>	<u>unk</u>
2) <u>Charter Hosp of Miami</u>	<u>11-0011</u>	}
3) <u>Miami Childrens Hospital</u>	<u>11-0199</u>	
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 10.08.92

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 conference
- (05) During 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 |
| <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) *NA*

(01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 1,000 .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: ----- \$ - .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 0 .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:

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) NA

(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: - - - - - \$ 0 .00

43. COLLATERAL SOURCE INFORMATION: NA

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: None.

Insured denied liability. Agreed to
nuisance value settlement to avoid a
costly defense of a NON-MERITORIOUS CLAIM

CONTACT PERSON: JOAN R. BRECKENRIDGE
TELEPHONE: (202) 682-3832

ADDRESS: PROFESSIONAL RISK MANAGEMENT SERVICES, INC.
1444 EYE STREET, N.W., SUITE 1100
WASHINGTON, D.C. 20005

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