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

9603201

DEPT. FILE NO.

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 96-23605-02-003

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 14140151
(See Table A)

2. EXCESS INSURER NAME: N/A INSURER CODE: 1N1A1111
(See Table A)

3a. HEALTH CARE PROVIDER: Lopez, Raul Ignacio
(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: 10111148151

3c. INSURED'S NAME: Ignacio R. Lopez, M.D.

STREET ADDRESS: 3661 South Miami Avenue, Suite 108

CITY: Miami STATE: FL ZIP: 33133 COUNTY CODE: 1011
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>M-0162005</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ 0.00</u>	<u>\$ 0.00</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: N/A)

6. PROFESSION OR BUSINESS: (Check One)

- (01) Physicians & Surgeons
- (02) Hospitals
- (03) Podiatrists
- (04) Dentist
- (05) Abortion Clinics
- (06) Ambulatory Surgical Centers
- (07) Crisis Stabilization Unit
- (08) Health Maintenance Organization

7. SPECIALTY CODE: 1810216111 (Applies to physicians, surgeons, and dentists.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check One)

- (01) In specialty code in Item 7, above.
- (02) In a different specialty.
- (03) In the specialty in Item 7 and another. Enter the additional specialty code here: N/A
- (04) Insured is not Board Certified. (see table C)

9. PLACE WHERE INJURY OCCURRED: (Check One)

- (01) Hospital Inpatient Facility
- (02) Emergency Room
- (03) Hospital Outpatient Facility
- (04) Nursing Home
- (05) Physician's Office
- (06) Patient's Home
- (07) Other Outpatient Facility
- (08) Other Location
- (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:
N/A

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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, missed fracture, fall in hospital. Recovery delayed.
- orary (04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
- (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 - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
- (09) Death

21. DATE OF SUIT, IF ANY: 10 / 18 / 96

21.1 CIRCUIT COURT CASE NUMBER: 96-16252 CA 01

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 1011 (SEE TABLE B)

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE TO NUMBER:

<u>DEFENDANT'S NAME (Last Name, First Name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE NO.</u>
1) <u>Stincer, Carlos Ernesto, M.D.</u>	<u>Unknown</u>	<u>Unknown</u>
2) <u>Menendez, Jose Martin, M.D.</u>	<u>44050</u>	<u>95-23605-03-003</u>
3) <u>Castillo, Cesar Augusto, M.D.</u>	<u>44050</u>	<u>95-23605-01-003</u>
4) _____	_____	_____
5) _____	_____	_____

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check One)

- (01) Yes (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 12 / 3 / 96

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 notice of appeal.
- (07) After notice of appeal is filed or post-judgment 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 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)

- | | |
|--|--|
| <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. |
|--|--|

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: \$ 737,500.00

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: \$ 0.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: \$ 8,253.00

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: \$ 737,500.00

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? <input type="checkbox"/> (01) Yes <input checked="" 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)

- (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:

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 INSURE TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Member discussed claim with insurance company personnel, defense counsel and medical experts.

CONTACT PERSON: Fred Scheriff, Miami Regional Claims Manager
TELEPHONE: (305) 442-4001

ADDRESS: Physicians Protective Trust Fund
2121 Ponce de Leon Boulevard, Suite 350
Coral Gables, Florida 33134

EHB/mor: (FB):PPTF:3962-11-25.SR:D/11-22[F12]

