

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

9702796

DEPT. FILE NO.

NOV 24 1997

INSURER'S CLAIM NUMBER: 96M06260

BUREAU OF PROPERTY
QUALITY FORMS & RATES

1. PRIMARY INSURER NAME: Frontier Insurance Company INSURER CODE: 09574
(See Table A)

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

3a. HEALTH CARE PROVIDER: Marin, Debra Sue
(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: 0048501

3c. INSURED'S NAME: Debra S. Marin, MD

STREET ADDRESS: 1290 Weston Road, Ste 310

CITY: Weston STATE: FL ZIP: 33326 COUNTY CODE: 10
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>RRM-0001360-1</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 (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
___ (03) Podiatrists ___ (06) Ambulatory Surgical Centers Organization

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and dentists.)
(See Table C) 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: 80267
___ (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: _____

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1. NAME OF INSTITUTION: N/A INSTITUTION CODE: _____ (See Table D)

2. LOCATION OF INSTITUTIONAL INJURY: (Check one) N/A
 (01) Patient's Room (05) Physical Therapy Dept. (09) Radiology
 (02) Operating Suite (06) Nursery (10) Emergency Room
 (03) Recovery Room (07) Critical Care Unit (11) Other _____
 (04) Labor & Delivery Room (08) Special Procedure Room _____

3. DATE OF OCCURRENCE: 10/25/91

DATE REPORTED TO INSURER: 10/10/96

14. INJURED PERSON'S AGE: 47 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S NAME: _____ (Circle one)

14.1 INJURED PERSON'S SEX: _____

ZIP: _____

CITY: Chicago

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Major depression, excessive sleeping & forgetfulness (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: Alleged failure to diagnose "bifrontal meningioma" 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: It is alleged that the insured failed to diagnose the bifrontal meningioma and as a result of this delay in diagnosis, patient sustained permanent brain damage. 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: Resection of the meningioma, CT of the brain 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: Brain Damage - Meningioma 19.

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27. COURT: (Check one)
- | | |
|---|--|
| <input checked="" 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 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)

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

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 0.00
- 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: ----- \$ 1250.00
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>350,000.00</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: ----- \$ 0.00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM: NA
- | | |
|--|----------------------|
| 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) N/A

- (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: ----- \$ 600

43. COLLATERAL SOURCE INFORMATION: N/A
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

- | | |
|---|--|
| 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: _____

The insured has consulted with medical experts, advised counsel and arranged for insurance regarding this incident.

CONTACT PERSON: Clive Smith
TELEPHONE: (854) 491-1078

ADDRESS 6360 N.W. 4th Way #303
At Lauderdale, FL 33309