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ABOUT JUAN PABLO ("J.P.") GONZALEZ-SIRGO

I was just a one year old when my parents arrived from Havana, Cuba to the United States in 1969. Growing up in Northwest Miami, I attended Comstock Elementary School, Kelsey L. Pharr Elementary School, and Allapattah Junior High School. Eventually, my family, which had grown to my parents and four boys, settled in Hialeah, Florida. My parents owned their own business, cleaning office buildings and restaurants such as Flanigan's and retail stores including Kmart and the old McCrory's Department Store in downtown Miami. I often worked in the family business in the evenings and weekends.

I am the oldest of my brothers. In Hialeah, I attended Palm Springs Junior High School and graduated from Hialeah High School in 1986. While at Hialeah High I participated in the Diversified Cooperative Training work program. I held jobs at Bojangles and Wendys fast food restaurants early in my high school days. I spent the last two years of high school working the 4pm-midnight shift at my Uncle's plastics factory in Hialeah.

After high school, I attended Miami-Dade Community College, North Campus, now known as Miami-Dade College and continued my education at Florida International University (FIU). In addition to working 30-40 hours a week as the night time dispatcher at City Gas Company while at FIU and carrying a full time student course schedule, I also served as the Sports Editor of my college paper and was a member of the Pre-Law Society. I borrowed and worked my way through college, graduating with Honors from FIU in 1990 with a degree in Political Science.

After college I took a year off to work and save money. My first job out of college was as a management trainee at Enterprise Rent-A-Car. As part of my responsibilities at Enterprise, I interacted with many claims adjusters who called on Enterprise to obtain rentals for their insureds after an accident. This is how I was introduced to the world of insurance and led to my next job as a claims adjuster at De La Torre (DLT) Insurance Adjusters in Miami. At DLT, I handled hundreds of claims on behalf of several insurance companies.
In 1991 I went off to law school. Having been admitted to a number of law schools, I chose Vanderbilt University School of Law, on a partial scholarship. Once again, I borrowed and worked my way through law school working as a Vanderbilt Reeve on campus. In my last year in law school I worked at a prominent insurance defense law firm.

Although I respect and learned a great deal from the individuals that I worked with during my time in claims handling and at an insurance defense law firm, I realized that my heart was not in representing the Goliaths of the world. After reading Jay Foonberg's How to Start and Build a Law Practice, I turned down interviews with some of the best law firms in Miami. In 1994, borrowing from credit cards, I started my own law practice in Hialeah, Florida. In 1996, I moved my office to Coral Gables, Florida where my practice has grown and remains today in the historic Douglas Entrance office complex. I also make my home in Coral Gables with my wife and "our" cats (they are really her cats). From day one in my practice, it has been about representing the "Davids" of the world. And I have never looked back. The insight that I gained working as a claims adjuster and working for an insurance defense law firm now serve my clients in working towards a just resolution of their claims.

I take pride in zealously representing those that have been wronged. Those injured as a result of wrongdoing. Insurance policyholders who sacrifice and work hard to make their premium payments and then find their claims delayed, ignored, lowballed, and/or denied when the need to file a claim becomes necessary, often in the midst of a tragic or catastrophic event. My job is simply to hold Big Insurance true to the promises that they make in the insurance policies that they sell. Not a dollar more. And not a dollar less. My mission is to hold wrongdoers accountable. I have been a member of The Florida Bar since 1994 and have tried numerous cases to verdict, including both jury and non-jury trials. I hold an "AV Preeminent" rating from Martindale-Hubbell, the highest rating available to lawyers. I am also admitted to practice before the U.S. District Court, Southern District of Florida, U.S. District Court, Middle District of Florida, U.S. District Court, Northern District of Florida, and the U.S. Court of Appeals, 11th Circuit. I have been certified as a life member of the Million Dollar Advocates Forum and the Multi-Million Dollar Advocates Forum. The Million Dollar Advocates Forum is recognized as one of the most prestigious groups of trial lawyers in the United States. Membership is limited to attorneys who have won million and multi-million dollar verdicts, awards, and settlements. Fewer than 1% of U.S. lawyers are members. I am a

lifetime member of the Florida International University Alumni Association and a sustaining member of the Vanderbilt University Alumni Association. I served a three (3) year term as a Member and Chair of Grievance Committee "C" of the Eleventh Judicial Circuit of the Florida Bar. I am also a Volunteer Lawyer with Lawyers for Children America.

I have significant experience representing clients in cases such as:

- *Personal Injury*
- *Wrongful Death*
- *Medical Malpractice*
- *Homeowners Property Insurance Claims (Fire, Water Damage, Hurricanes, Windstorm, Flood, etc.)*
- *Condominiums Property Insurance Claims (Fire, Water Damage, Hurricanes, Windstorm, Flood, etc.)*
- *Business Property Insurance Claims (Fire, Water Damage, Hurricanes, Windstorm, Flood, etc.)*
- *Business Interruption Insurance Claims*
- *Life Insurance Claims*
- *Long Term Disability Insurance Claims*
- *Short Term Disability Insurance Claims*
- *Long Term Care Insurance Claims*
- *Health/HMO Individual Policy Insurance Claims*
- *Stolen Auto, Yachts, Boat, Truck, Motorcycle Insurance Claims*
- *Travel Insurance Claims*
- *Credit Insurance Claims*
- *Wedding Insurance Claims*
- *Critical Illness Insurance Claims*
- *Occupational Accident/Truckers Insurance Claims*

Many of my clients come to me as a result of referrals from other attorneys, including from out of state lawyers and lawyers from other countries. I welcome these co-counsel opportunities and routinely pay referral fees in accordance with the rules regulating the Florida Bar and Florida law. I recognize the trust placed in me by our referring attorneys and so I make it a point to keep my referring attorneys in the loop throughout my representation, from the initial intake through the conclusion of the case.

Please call me at (305) 461-1095 or toll free at (866) 71-CLAIM or visit my website for more information at www.YourAttorneys.com. You can also email me directly at jp@yourattorneys.com

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MOTOR VEHICLE PERSONAL INJURY

REPRESENTATIVE CASES

The accounts of the representative cases contained in this brochure are intended to illustrate the results of our work ethic and experience. Of course, each case is unique and the results in one case do not necessarily indicate the quality or value of any other case.

We have handled numerous cases involving serious injuries or wrongful death caused by automobile, trucking, motorcycle, bicycle, and pedestrian accidents. Below is a sampling of some of our more interesting cases.

WRONGFUL DEATH CASE SETTLES FOR $2,500,000 MILLION DOLLARS

In this wrongful death case J.P. was asked by counsel in Collier County to help represent a 19 year old young man who was killed as he rode his bicycle home from work late one night when he was rear ended by a drunk driver. Our client worked as a dishwasher earning a small wage. He was not a legal resident of the United States. He was not married and did not have any kids. He was survived by his parents and siblings who lived in their home country in Latin America. The facts supporting liability in this case were aggravated in that the driver of the auto that struck our client also attempted to flee the scene of the accident. The insurance carrier's position was that even though the incident was tragic the value of the claim was nominal because of the minimal economic damages and the fact that our client was not survived by a spouse or children. As a result, we travelled to Guatemala to gather evidence to substantiate and bolster damages from our client's surviving parents and siblings. We were able to then present a compelling case for damages at the mediation of the case resulting in a recovery of $2,500,000.

SEVEN FIGURE SETTLEMENT REACHED IN TOW TRUCK ACCIDENT CASE

In this case, attorneys Russell A. Dohan and J.P. Gonzalez-Sirgo reached a seven figures above policy limits settlement, after a 1 week jury trial where the jury deadlocked 5 to 1 in favor of our client's case resulting in a mistrial.
The case arose from a wrongful death single vehicle accident. The decedent was a 35 year old husband and father of three young girls (one of whom had not been born yet), who had just taken a job with the Defendant Towing Company. The vehicle involved was a large tow truck which suffered a right front tire failure while traveling on I-75. This failure caused the large tow truck to leave the roadway and enter the canal, where our client drowned. The essential allegation was that the tow truck company failed to maintain the vehicle, and more specifically, the tire, properly. It was ultimately discovered that the tow truck company knew the tire needed to be replaced before the incident, as early as when the vehicle was purchased several months earlier. It was also discovered that four days before the incident, the Florida Highway Patrol had inspected the tire and failed the truck for use by FHP because of the poor condition of the tire. The defense was essentially that our client took the wrong truck that day, and that he, himself, knew or should have known the tire was unsafe to drive on. The defense also alleged that our client's driving following the tire failure itself contributed to the vehicle ending up in the canal.
After a 1 week jury trial where the jury deadlocked 5 to 1 in favor of our client's case resulting in a mistrial, a seven figures above policy limits settlement was reached by the parties.

$940,000 POLICY LIMITS RECOVERY FOR INJURED MOTORIST

Attorneys Russell A. Dohan and J.P. Gonzalez-Sirgo recover $940,000 for injured motorist. Our 49 year old client was involved in an automobile accident. The Defendant's driver, in a 2005 GMC Large Cargo Van, traveling at a speed of 45mph on the Palmetto Expressway in Miami, Florida, rear-ended a stopped vehicle which then struck the stopped vehicle of our client. Our client was noted to have a "possible" injury at the scene on the Police Report, due to his complaints to the Officer. Fire Rescue did arrive at the scene, and although our client did again complain to them of generalized shock and pain, our client did not request to be transported to the ER, as he had a job to attend

to and was on the way to the job site that morning. Later, our client went home, rested and took some anti-inflamatories. The next day he made an appointment with an orthopedic doctor. The doctor diagnosed him with left shoulder, neck, and back sprains. Over the course of the next three years, our client incurred $350,000 in medical expenses, as a result of several major surgeries, including a rotator cuff repair, lumbar diskogram, and unfortunately a lumbar fusion. He also underwent a number of outpatient procedures, such as epidural injections. Our client's injuries left him totally disabled at 50 years old. Further, as a result of his pain and disability, he was admitted to the hospital for a major psychiatric depression. He was unable to work and applied for Social Security Disability benefits. Citing our client's pre-existing medical conditions (which were fairly extensive), the Defendant's insurance carrier only offered to settle the case for the amount of our client's medical bills. We then filed a lawsuit. After mediation was unsuccessful and shortly before the trial of the case, the Defendant's insurance carrier paid the entire insurance policy limits available.

$900,000 RECOVERY FOR VICTIMS OF MOTORCYCLE ACCIDENT

In this case, our clients were best friends who were out riding on one of their motorcycles. As they approached the intersection of Columbus Boulevard traveling east on Coral Way in Coral Gables, they noticed a car inching westward from the stop sign at the intersection. The driver of the motorcycle blinked the high beams and started to downshift. The driver of the car, nonetheless, attempted a left turn. The driver of the motorcycle was not able to avoid the accident and a collision occurred. Both the driver of the motorcycle and the passenger where thrown from the motorcycle and later airlifted to JMH Ryder Trauma Center with multiple injuries resulting from the accident. Among his injuries, the driver of the motorcycle suffered a fracture of the left hip. The driver of the motorcycle incurred approximately $60,000.00 in medical bills. The passenger of the motorcycle, too, suffered multiple injuries. Among his injuries, he sustained a closed head injury with a facial fracture and a right ankle fracture. The passenger of the motorcycle incurred approximately $66,000.00 in medical bills.

During the prosecution of the case, we argued that the driver of the automobile failed to yield the right of way when he entered the intersection of Coral Way and Columbus Boulevard. The defendant driver defended the case on a number of grounds: that the driver of the motorcycle was speeding, based on statements made by an independent witness that the motorcycle was traveling at approximately 85 miles per hour at the time of the collision; that both the driver of the motorcycle and the passenger were intoxicated at the time of the accident based on the results present in the toxicology report contained in the hospital records; that the layout of the subject intersection was negligently designed, raising the Florida Department of Transportation as a possible Fabre defendant; and that the driver of the motorcycle could have avoided the accident.

During discovery the observations made by the independent witness to police at the scene evaporated. We were also able to demonstrate that although the toxicology report showed alcohol in the systems of both the driver of the motorcycle and the passenger, the driver had an alcohol level well below the legal limit. The deposition testimony of defendant's accident reconstruction expert proved a key to defendant's position that the layout of the intersection was part of the problem and that the driver of the motorcycle could have avoided the accident. Through deposition banks we obtained previous deposition testimony of defendant's accident

reconstruction expert. With this in hand, we set out to take an adversarial video-deposition of the expert. At his deposition, we were able to establish the following:

1. That the motorcycle was traveling at approximately 35 miles per hour at the time of impact not much over the 30 mile per hour posted limit and clearly much less than the alleged eyewitness estimate.
2. That the expert had previously offered a different opinion in another case as to what the average reaction time for a driver is, in reacting to a peril, which was in direct contradiction to his opinion in our case.
3. That the type of intersection problems identified by defendant were design in nature and therefore fell within the zone of immunity granted to the government.

The case settled after this deposition.

RECOVERY OF $610,000 IN RENTAL CAR ACCIDENT CASE

In this case, our client was a passenger in a rental car that was rented by her husband while they visited Miami from their home country. The husband listed himself as the only would be driver of the car on the rental car application. He also purchased the supplemental liability policy that was offered by the rental car company. On the day of the accident, the husband was suffering from a migraine and did not feel well enough to drive. Not feeling well, he asked his adult son to drive. Unfortunately, the son got into an accident for which he was primarily at fault. As a result of the accident, our client suffered a pelvic fracture.

Our position against the rental car company rested on 3 theories of liability:

1. That the rental car company is liable for the negligence of the renter and/or driver of the rental automobile as the owner of the automobile.
2. That the rental car company is liable for the negligence of the non-rental car involved in the accident under an underinsured motorist theory of liability up to the $1M limit of the supplemental liability policy purchased by our client's husband. The non-rental vehicle carried only $10,000 of liability coverage. That the rental car company failed to offer UM limits in the amount of the liability limits to its renter and/or to obtain a valid rejection of equivalent UM limits in compliance with the UM statute and relevant case law.
3. That the rental car company is liable under a spoliation of evidence theory of liability. We made several written requests to inspect the subject rental car prior to its repair or destruction. This was particularly important in light of the fact that our client's seat belt was inoperable. In spite of our requests for an inspection, the rental car company repaired or destroyed the subject vehicle prior to allowing any inspection.

Under the above facts, we successfully argued that any statutory limits on any recovery would not be applicable and that under a spoliation of evidence theory not even the limit of the supplemental policy would be applicable as the rental car company is directly responsible for its own active negligence.

WRONGFUL DEATH CASE SETTLES FOR $525,000

In this tragic case, our clients were driving westbound on State Road 90 in Miami, Florida on their way to Marco Island to vacation with family. The husband driver, his wife, their baby, and our clients' cousin, were along for the trip. Sadly, the family never made it to Marco Island. As the family approached the intersection of Southwest 137th Avenue and 8th Street, a Range Rover traveling southbound on Southwest 137th Avenue t-boned our clients' vehicle on the passenger side resulting in the death of the 21 year old wife. The wife was survived by her husband, their baby, and her parents.
The driver of the SUV, a prominent Miami businessman, claimed that the accident was caused by the husband driver speeding and running a red light. This, he argued, was supported by the traffic homicide investigation completed by the police. The police cited the husband driver for running a red light and causing the accident. The driver of the SUV also relied on the statement given

to police, as summarized in the traffic homicide report, by an independent witness in support of his position. The husband driver, however, held firm that the driver of the SUV was the one who ran the red light.

J.P. was retained to represent the estate of the deceased wife, the husband driver, the baby, and the deceased wife's parents just 2 months prior to the statute of limitations expiring. Prior to retaining our firm, two prominent law firms in Miami had turned down our clients' case. Once retained, our investigation revealed a different story. Rather than relying on the witness statements summarized in the traffic homicide report, we sought out the actual tape recordings of the witness' statements. After listening to the tapes, it became apparent that the witnesses were not crystal clear as to who ran the red light and were not exactly sure as to what happened. Most of the thoughts offered by the witnesses were of "after-the-fact." Our subsequent deposition of the main witness revealed inconsistencies in the witness' testimony which brought his credibility into question. We also discovered through discovery that the driver of the SUV was on his cell phone and lost at the time of the accident.

With the above discoveries and the use of an accident reconstruction expert, an economist, a before and after video documentary of the family's life, and an expert on the effects of cell phone use while driving, we were able to secure a settlement, in a hotly contested liability case, at the mediation of the case that served as the foundation for the baby's future.

$500,000 SETTLEMENT IN BICYCLE ACCIDENT CASE

Our client was riding her bicycle on her way home from her job at Publix as a dairy stocker earning $13.50/hour in the early evening when a sixteen year old minor struck her while making a left turn in his 6,025 pound Dodge Ram 1500 Pick Up, which vehicle was legally owned by his father. Our client was on her 30 pound white bicycle with reflectors. The incident occurred at the intersection of SW 96 Street and SW 137 Avenue. The intersection is well lit with four large street lights (one at each corner of the intersection). Our client was very familiar with this route as she took it every day to and from work. Prior to entering the intersection to cross SW 96 Street heading South, our client came to a stop because there was traffic running East and West on SW 96 street, which means that there was a red light for the driver as he was intending on making a left turn from SW 137 Avenue to head East on SW 96 Street. When the traffic stopped, our client entered the intersection. She was almost across the intersection when she heard an engine roaring and she was violently struck by the Dodge Ram. Our client was thrown onto the grassy parkway. The driver struck our client with sufficient force to cause two cracks to the front grill of the Dodge Ram.

Our 54 year old client suffered multiple traumas as a result of the incident including a left periorbital bruise, frontal scalp laceration, a contusion on her left hand, fractures of the transverse processes of T12, L1, L2, L3, and L4, multiple rib fractures, she underwent a video assisted thoracic surgery to evacuate a residual blood clot in her lungs, and suffered several scars to the right side of her body including a scar under her right breast.

The insurance carrier for the driver contested liability and the extent of damages. The case settled for the policy limits after litigation was commenced.

MOTOR VEHICLE PERSONAL INJURY

REPRESENTATIVE CASES

$340,850 JURY VERDICT FOR INJURED PALM BEACH DEPUTY SHERRIFF

In this case attorneys Russell A. Dohan and J.P. Gonzalez-Sirgo obtained a jury verdict of $340,850.00 on behalf of a 52 year old female Palm Beach Deputy Sherriff. The Deputy was involved in an auto accident wherein she suffered injuries to her neck and back. She treated for these injuries conservatively with physical therapy and pain management. When her symptoms persisted she underwent a course of three epidural injections. The pain did not resolve. Her treating doctors recommended surgery but the Sherriff had not yet undergone the surgery at the time of trial. The defendant was insured by State Farm Insurance Company. State Farm offered to settle the case for $50,000.00 prior to trial. The defendant stipulated to liability at the time of trial but defended the case based on State Farm's expert's opinion that the injuries pre-existed the accident and that the Sherriff's complaints were psychologically based. At trial, these defenses were proven to be without merit. A Palm Beach jury returned a verdict of $340,850.00 in favor of the Sherriff after a three day trial. Defendant's policy of insurance with State Farm had a limit of $100,000. Nonetheless, the full amount of the jury verdict was recovered against State Farm.

$325,000 POLICY LIMITS UNDERINSURED MOTORIST INSURANCE CLAIM RECOVERY FOR FROZEN SHOULDER

Our client was injured while on the job as a bus driver when another vehicle crashed into his bus. Following the incident, our client was seen by doctors through his workers compensation carrier related to pain to his left shoulder. An MRI was ordered. The results of the MRI indicated a micro size stress fracture involving the shoulder bone head. Some rotator cuff tendon inflammation was also noted. He was then referred to an orthopedic surgeon. Our client was examined by the orthopedic surgeon who gave him an injection into his shoulder, Percocet, and a prescription for physical therapy three times a week. For safety reasons, he was told to not work as a bus driver due to the use of only one shoulder. With this treatment plan, his symptoms did not improve. At the follow up consultation it was assessed that our client possibly developed scar tissue which did not allow him to have full range of motion. He was given Ambien for sleep, because the shoulder pain was affecting his sleep, and continued physical therapy. Subsequently, after no improvement, the orthopedic surgeon recommended surgery due to his decreased range of motion and constant pain. The doctor expressed the need for the patient to address his Coumdain dosing (as to when to stop it, prior to or after surgery, as our client was chronically on a blood thinner, Coumadin, due to two previous deep vein blood clots which prevents him from taking anti-inflammatory medication). A preoperative physical was given for surgery clearance. Our client then underwent surgery. While our client was under anesthesia his range of motion was examined and found to be limited in all planes. He was manipulated in all planes with steady pressure until the adhesion released. A scope was then placed inside the shoulder to clear away any extra growth and inflamed tissue. After the surgery, our client was examined by the surgeon and some improvement was noted. He continued physical therapy but still complained of pain going down his arm and back with swelling below his shoulder blade. Two months after his operation his range of motion, especially reaching behind, was not as full in the left arm compared to the right. Our client experienced what is commonly known as a frozen shoulder or adhesive capsulitis. The pain in the shoulder is due to inflammation of the surrounding tendons; as a result, range of motion in the shoulder is lost.

The driver of the car that crashed into our client's bus only carried $25,000 of insurance which they paid. Our client was also eligible for up to $300,000 worth of underinsured motorist coverage (UIM) available under the insurance policy for the bus. Based on our evaluation of the case, we determined that the value of our client's case merited payment of the $300,000 of UIM coverage. As such, we demanded that the UIM insurance company tender or pay the $300,000. In response, the insurance company mailed us a check for $24,000. We rejected this offer, returned the check, and filed a lawsuit on behalf of our client in the Circuit Court for Miami-Dade County. In response, the

insurance company removed the case to federal court and litigation commenced. Ultimately, the insurance company tendered or paid the full $300,000 of available UIM coverage.

SIX FIGURE UNINSURED MOTORIST ABOVE POLICY LIMITS RECOVERY

Our client was involved in a hit and run accident wherein he injured a shoulder. For the following 5 months our client was unrepresented in his dealings with his uninsured motorist insurance company, with his insurance company ("the carrier") having unfettered access to him. The carrier obtained a statement from our client and processed the claim with our client's full cooperation and without the advice or representation of counsel. After becoming disillusioned with the way his carrier was handling the claim, our client decided to come see us.

Shortly thereafter, we sent a demand to the carrier offering to accept the policy limits of $100,000 as full settlement of the claim. We authorized the carrier to review its own PIP file, including the IMEs our client was requested to submit to under the PIP portion of the policy. Although the doctor who conducted the IME is well known to be defense oriented in his opinions, he concurred with our client's treating physician and opined that our client needed surgery to a shoulder. We also authorized the carrier to obtain any medical records it wanted. Of course, the PIP file would have contained most of these records. In fact, our client's PIP and Med Pay coverages in the amount of $15,000 had already been exhausted. Our position was that the carrier would not have paid these coverages without having had reviewed the medical records and having found that all of the treatment that our client had received was reasonable and medically necessary. We also included the police report and color copies of photos showing the substantial property damage that our client's truck sustained. Liability was never or should have never been an issue in this case, as the semi-truck that took a stop sign and pinned our client's truck into a utility pole never even stopped at the scene after the accident. Our client's son was a passenger in the truck and witnessed his father's injury. With the demand we also included the MRI reports that were in our possession which showed the seriousness of the injury. At the time that we sent the demand, our client had already incurred more than $45,000 in medical bills. We highlighted this in our demand and we also pointed out that our client was taking numerous pain medications, was going to need future treatment, and that he had also received an epidural block to assist with the pain. In light of all of the above information that was in the carrier's possession, the carrier should have immediately tendered the policy limits.

Instead we received a request from the carrier requesting

that our client sign an affidavit stating that he had no other insurance. That executed affidavit was faxed to the carrier immediately. In the interim, the carrier claimed that it was trying to obtain medical records to be able to evaluate

MOTOR VEHICLE PERSONAL INJURY

REPRESENTATIVE CASES

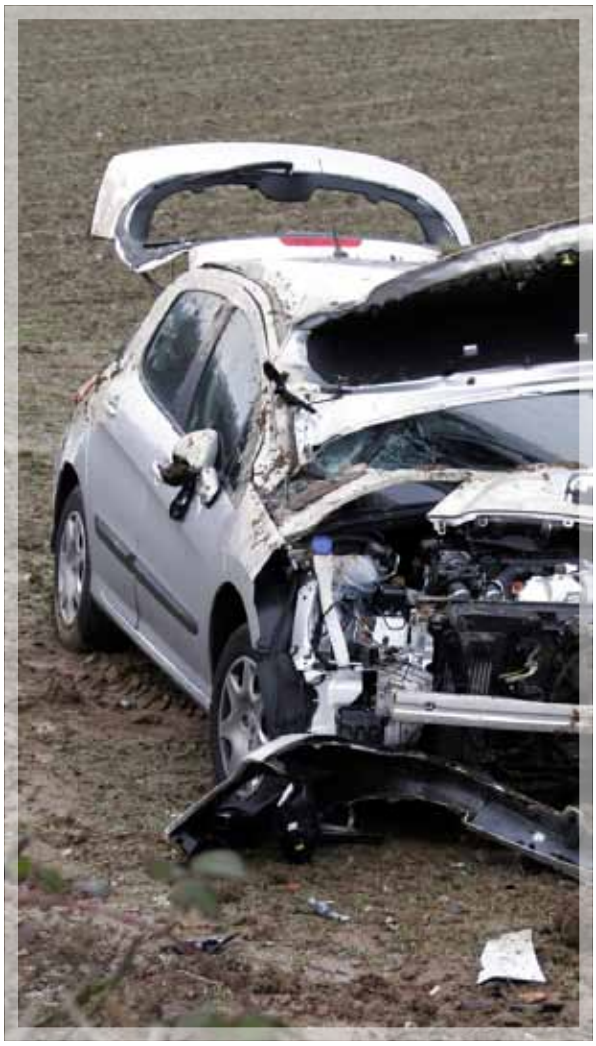
SIX FIGURE UNINSURED MOTORIST ABOVE POLICY LIMITS RECOVERY (CONTINUED)

the claim although it was abundantly clear that the carrier had more than enough information to tender the policy limits. The carrier requested an extension of time in which to respond to our demand which extension request we rejected. Our offer to settle for the policy limits expired. We then filed a Civil Remedy Notice of Insurer Violation with the Florida Department of Financial Services. This, in effect, bought the carrier an additional 60 days in which to "cure" the defect of not timely tendering the policy limits, by tendering the policy limits. It also bought the carrier an additional 60 days in which to obtain whatever additional information it deemed necessary in spite of the fact that the carrier already had all of the information it needed in order to determine that our client's claim was obviously worth more than the policy limits. We then wrote the carrier reminding them that the 60 day period purchased by the filing of the civil remedy notice would soon expire and that they could "cure" the defect by tendering the policy limits. During this entire 60 day period we did not hear one word from the carrier.

Upon expiration of the 60 day period, we filed suit. The carrier then tendered the policy limits immediately after our suit was filed. We rejected the tender and returned the check advising the carrier that we now would be seeking the full value of the claim. Just before trial was to begin, the case was confidentially settled for an amount in excess of the policy limits.

JURY VERDICT FOR VICTIM OF AUTOMOBILE CRASH

Attorneys Russell Dohan and J.P. Gonzalez-Sirgo obtained a jury verdict beating State Farm's pre-trial offers in favor of a victim of an automobile crash. Our client was a passenger in a car that was rear ended by a tow truck driver. The driver that caused the crash admitted that he was at fault for the collision but denied the cause and extent of the damages and injuries claimed by our client.



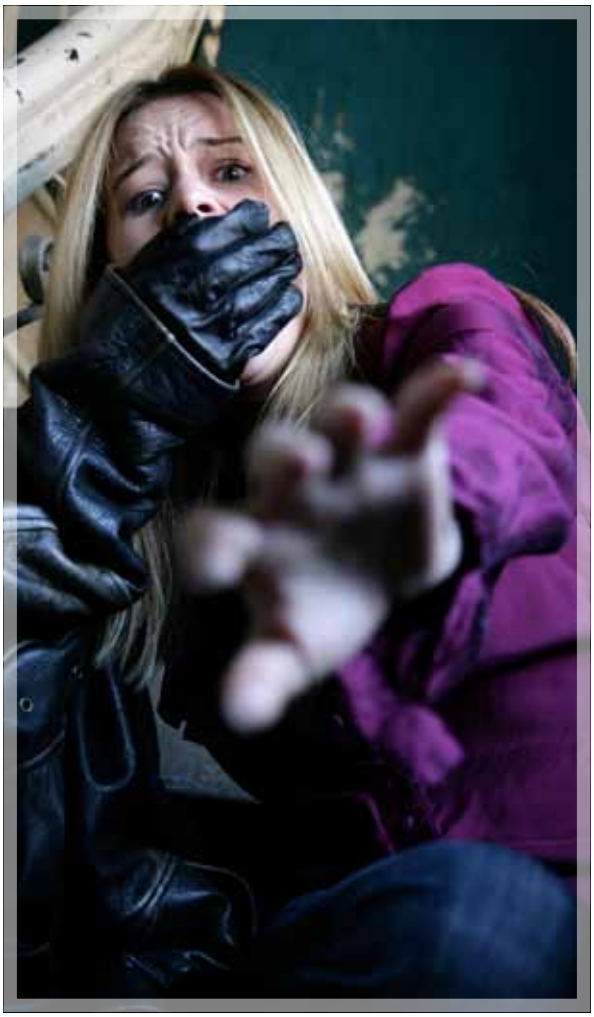
Our client claimed injuries to her neck and back as caused by the crash. The driver of the tow truck claimed that our client's complaints pre-existed the crash. Our client, in fact, had some pre-existing complaints to go along with other extensive medical problems that were not related to the claimed injuries. After listening to the evidence, the jury awarded an amount in excess of State Farm's pre-trial offers.

PREMISES LIABILITY PERSONAL INJURY

REPRESENTATIVE CASES

We have handled many cases involving serious injuries caused by the negligence of those responsible for maintaining premises safe, such as property owners, big box retailers, restaurants, apartment buildings, clubs, and other commercial spaces. Below are a couple of our more interesting cases.

$650,000 RECOVERY FOR SEXUAL ASSAULT



In this case we were retained by the father of a 13 year old girl that was sexually assaulted inside their apartment when she came home from school by an intruder that was hiding behind her bedroom door. Our client was fondled and forced to perform oral sex on the intruder. Our client did not incur any physical injuries. Our claim was limited to the emotional injuries inflicted on our client. Our investigation revealed a lengthy history of prior crime at the subject apartment complex including prior sexual crimes. Our investigation also discovered that the apartment complex had not taken any action to provide a safer environment for its tenants despite its knowledge of the criminal activity on the property. On behalf of our client, we brought suit against the apartment complex and its management company. In the midst of the litigation the assailant was arrested attempting to commit a similar crime at a different apartment complex. The assailant turned out to be a serial sexual offender. The Defendants blamed the father for not supervising his daughter (he was out at a job interview at the time of the assault) and she was home alone. The child's mother was living in Europe. The Defendants also questioned whether the assailant was let inside the apartment by the child since they claimed that there was no evidence of forced entry. The Defendants also argued that there was nothing they could do to stop the crime because the child was targeted by the assailant. They retained an ex-FBI agent as an expert to opine as to many of these matters. The property manager also testified that they had no knowledge of any prior sexual assaults on the property. After substantial litigation, the case settled after we uncovered prior police
reports for prior sexual assaults at the property wherein the police officers noted that the same property manager that testified in our case that she was not aware of any prior sexual assaults on the property was advised of these prior sexual assaults.

PREMISES LIABILITY PERSONAL INJURY

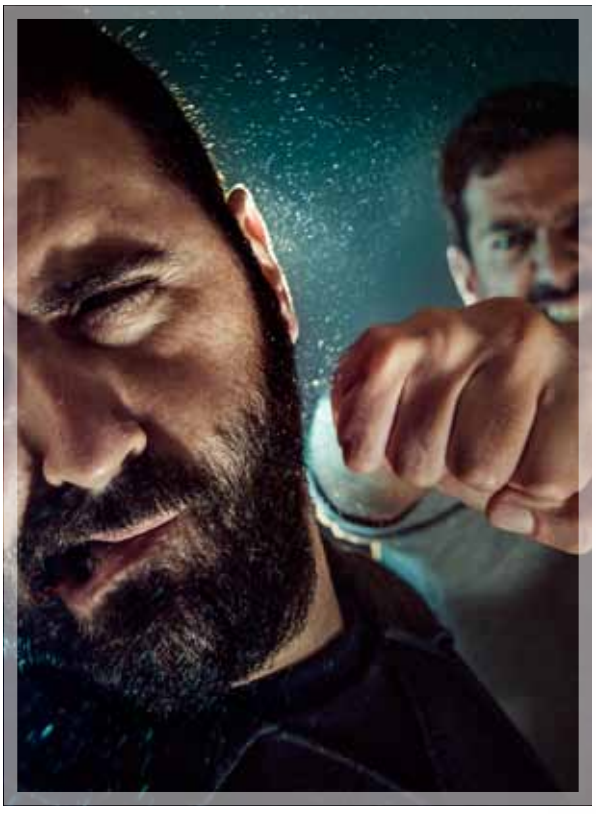
REPRESENTATIVE CASES

$240,000 RECOVERY ON $9,000 POLICY LIMIT

In the early morning hours of January 29, our client, a taxi cab driver, was waiting outside a popular "Gentlemen's Club" (Club") in Broward County, Florida for a fare, as they closedup for the night. He knew most of the people there and was chatting with the valets. While waiting, several young men came running out of the club. They were visibly upset, so our client told them to calm down and asked them if they needed a ride. In the interim, about a half dozen
employees of the Club came running out the front door and a fight ensued between them and the young men. Our client was caught in the middle, was struck and fell to the ground, suffering facial fractures as a result of the incident.

We placed the Club on notice of our representation and requested the Club's insurance policy. The response came from the "local independent adjuster" assigned by the Club's insurance company that the subject insurance policy contained an assault and battery endorsement with a limit of $100,000. Months later, in May, after many requests, the adjuster finally sent a copy of the insurance policy. Our client gave a statement to the insurance company a month later.

We made a comprehensive demand on September 25 which included all of the medical records and bills, for the Club's "policy limits". As reflected in the letter, at that time, our client had given us authority to accept the Club's limits, whatever they might be. Our client wanted to avoid litigation. This offer was set to expire on October 27. On that date, the adjuster called and offered as an excuse as to why he has been unable to evaluate the claim: that he had "just received" the demand packet. However, unbeknownst to him, the packet had been couriered on the 25th and thus could not have been delayed in the mail. Regardless, we courteously granted an extension to November 10. On November 9th, the adjuster responded this time, not with an offer, but with a request for additional information. We provided that information on November 19 and gave another extension to tender the limits to December 1. No response or additional request was received by that date and a lawsuit was filed, at which time the matter was forced to proceed into litigation.



Also, during this back and forth, no mention was made as to exact amount of the "policy limits" by the adjuster. During the lawsuit, for the first time in correspondence from the Club's assigned defense lawyer, the insurance company took the position that the assault and battery

endorsement in their policy did, in fact, apply and that their policy limits were $100,000, declining limits, based on expenses and claims. No indication in that letter was made as to how much remained on the policy. A month later $9,000 was offered as the amount of policy limits remaining due to "funds expended on another claim". That was clearly not acceptable. Once that amount was exhausted on the defense of the case, the insurance company for the Club withdrew its defense of the Club, subjecting it to personal liability. Facing a trial, and the additional mounting costs of the defense, the parties entered into a Coblentz agreement and consent judgment, for an amount chosen by an independent arbitrator and a Civil Remedy Notice of Insurer Violation was filed with the Florida Department of Financial Services. Facing a bad faith lawsuit, new counsel for the insurance company requested mediation. The case was settled at mediation for over 26 times the "policy limits".

$240,000 RECOVERY FOR TRIP AND FALL INJURY

Attorneys Russell A. Dohan and J.P. Gonzalez-Sirgo recover $240,000 for injured trip and fall victim. Our 43 year old client attended a doctor's visit at a Miami hospital. As our client was walking alongside her mother, who accompanied her to the visit, her mother tripped on something and began to lose her balance. Our client tried to prevent her mother from falling, however, ended up tripping and falling herself as a result of the same condition. When our client, her mother, and other witnesses looked around for the cause of the trip and fall, they saw that the tiles in the hallway (which appeared symmetrical and flat to the naked eye) were actually raised and elevated from the remainder of the floor. Our client was unable to pick herself up from the floor, and staff members from the medical center came to her aid, including a nurse who stated immediately that "people trip on those tiles there all the time". The security officer who works full time at the premises, testified at this deposition that immediately following our client's fall, he placed a yellow caution sign over the tiles to prevent subsequent falls. The pictures of the scene that were taken prior to the tile repair, also show that duct tape was placed directly over the raised tiles. A couple of weeks following our client's fall, the tiles were repaired and leveled appropriately. Despite several cameras which clearly pointed to the direction of our client's fall, the Defendant represented that they do not have any video surveillance of the fall.

Our client suffered a left femur fracture. Immediate surgical intervention was necessary to repair her hip fracture. Our client had an extensive list of pre-existing medical conditions and had been previously awarded Social Security Disability benefits for unrelated conditions. Shortly before trial, the case was settled for $240,000.

We have handled hundreds of property insurance claims including residential, commercial, business, and condominium insurance policies including losses caused by hurricanes, windstorm, flood claims in federal court, fires, water, lightning, and other losses. Many of the claims that we have handled concern issues raised by the insurance company regarding examinations under oath, fraud allegations, and other coverage defenses. Below is a sampling of some of our more interesting cases.We have handled numerous cases involving serious injuries caused by the negligence of medical providers. Below we discuss some of these cases.

MEDICAL MALPRACTICE

REPRESENTATIVE CASES

$440,000 HOSPITAL MALPRACTICE CONFIDENTIAL SETTLEMENT

In this case, our client fell while washing her floors at home suffering fractures to her right femur. She was transported to the hospital. The fracture required a cast which resulted in the immobilization of our client who was admitted as an in-patient into the hospital. During her stay at the hospital, our client developed pressure ulcers on her heel and coccyx. These ulcers were caused by the hospital's failure to timely and properly assess, monitor, and care for our client who was at risk for developing pressure ulcers because of her immobilization and failed to timely and properly assess, monitor, and care for our client after she developed the pressure ulcers. The nurses at the hospital also failed to assess our client's risk for skin breakdown as well as her skin integrity and did not use proper risk assessment tools to determine our client's risk for skin breakdown. In addition, the nurses failed to turn and reposition our client while she was in Buck's traction and failed to properly evaluate and/or implement sufficient support surfaces for our client. The nurses also failed to properly assess our client's skin. Their failure to monitor and assist our client with reasonable frequency was a proximate cause of the patient's development of a pressure ulcer on her heel and her coccyx and infection. The nurses documented that our client had a stage III sacral pressure ulcer with eschar on 10/29, yet debridement did not occur until 11/6. This delay in treatment caused a delay in healing of the pressure ulcer as well as an increased length of stay in the hospital.

Medical malpractice cases in Florida are very difficult for a lot of reasons. One of these reasons is the expensive and lengthy required process that a claimant has to go through before instituting a law suit. At the conclusion of the pre-suit process in this case, the hospital refused to settle the case. The case was settled after litigation was commenced.

SIX FIGURE MEDICAL MALPRACTICE CONFIDENTIAL SETTLEMENT

Our clients brought their 9 month old son to the hospital with complaints of a fever on New Year's Eve. Their son was released about one week later, inexplicably, with 2nd to 3rd degree burns to his left wrist. Later it was discovered that the injuries were caused by intravenous infiltration. Infiltration occurs when an IV fluid or medication accidentally enters the surrounding tissue rather than the vein. The injuries to the baby required surgery and a skin graft. Hospital nurses are responsible for assessing, planning, implementing and evaluating nursing care for their patients. Nurses are responsible for establishing goals and prioritizing nursing care. Nurses are responsible for accurate documentation of all pertinent observations and nursing interventions relevant to the patient's progress.

The nursing care provided to our client by the employees of the hospital fell below the minimum standard of care in the following ways:

1. Causing intravenous infiltration;
2. Failing to adequately assess for signs and symptoms of intravenous infiltration;
3. Failing to promptly notify the physician in a timely manner when signs and symptoms of intravenous infiltration evidenced themselves;
4. Failing to adequately monitor/observe/record the progression of the burn wound appropriately;
5. Failing to order a nursing consultation for a wound care nurse, case management nurse and social worker for prompt intervention in order to prevent further compromise of the wound to the wrist;
6. Failing to provide adequate discharge instructions and timely follow-up appointments in order to prevent further compromise of the wound to the right wrist;
7. Failure to adequately train its nursing staff;
8. Failing to properly supervise its nursing staff.

The above acts and/or omissions by the hospital caused or contributed to extravasations of Acyclovir to result in the injury of a 2nd to 3rd degree burns to the baby's wrist. We brought a medical malpractice lawsuit against the hospital on behalf of the family and succeeded in obtaining a six figure confidential settlement for our clients as a result of the nursing and hospital negligence.

SIX FIGURE DENTAL MALPRACTICE CONFIDENTIAL SETTLEMENT

In this case, our client sought the services of a general dentist in hopes of improving her smile. The dentist created a treatment plan consisting of placement of numerous dental implants. During the course of our client's treatment the dentist placed an implant into the mandibular canal which impinged on a nerve. Within days of this implant our client continued to complain to the dentist of a feeling of numbness on her lip and chin, known as paresthesia. The dentist, however, failed to remove or back out the implant in a timely fashion therefore resulting in permanent paresthesia or permanent nerve injury. In addition, many of the other implants were improperly placed. Our client retained our services after entering into a written settlement agreement and release with the dentist, on her own. This made the case substantially more difficult. In spite of the release signed by our client, the case settled on the first day of trial for a confidential six figure settlement.

With that said, DON'T EVER SIGN A SETTLEMENT AGREEMENT OR RELEASE WITHOUT CONSULTING A LAWYER FIRST.

PROPERTY INSURANCE CLAIMS

REPRESENTATIVE CASES

We have handled hundreds of property insurance claims including residential, commercial, business, and condominium insurance policies including losses caused by hurricanes, windstorm, flood claims in federal court, fires, water, lightning, and other losses. Many of the claims that we have handled concern issues raised by the insurance company regarding examinations under oath, fraud allegations, and other coverage defenses. Below is a sampling of some of our more interesting cases.

$2,500,000 GROSS RECOVERY FOR CONDOMINIUM ASSOCIATION IN FEDERAL FLOOD INSURANCE CLAIM

In this case, we represented a condominium association in Key Largo, Florida that sustained flood damages to its buildings as a result of Hurricane Wilma on October 25, 2005. At the time of the loss, the condominium association board hired public adjusters to represent its interests in the insurance claim. The insurance company assessed the damages and issued payments. The insured disagreed with the amount paid by the insurance company and invoked the appraisal provision of the policy. After years of the parties going back and forth over a number of issues, we were retained in 2013. We filed a lawsuit in federal court in Key West, Florida. The insurance company alleged that the insured failed to submit legally sufficient proofs of loss and that appraisal was not appropriate under the policy because the parties did not agree on the scope of damages. The case was set for trial for January 2015. With pending motions to compel appraisal and for summary judgment the case settled at mediation for a gross recovery of over $2,500,000 in 2014, just over one year after our involvement in this protracted claim.

$1,000,000 CONDOMINIUM HURRICANE INSURANCE CLAIM GROSS RECOVERY

In this case our client was the board of a condominium association. The condominium association contracted J.P. and associated counsel years after the loss. The main issue in the case was the insurance company's position that the Association failed to provide notice of the loss until 2 ½ years after the loss in violation of the insurance policy requirement that the insured provide prompt notice of the loss. The insurance carrier also defended the litigation on other grounds and removed the case to federal court. Through experts we were able to prove that the insurance company was not prejudiced by any alleged delay in the Association's "late" notice to the insurance company of the claim. After significant litigation, we were able to get the case settled at mediation.

HOMEOWNER'S INSURANCE CLAIM SETTLES FOR $587,500

In this case, the homeowner came home one night to discover that a plumbing pipe in the upstairs bathroom had burst inundating the house with water causing damage to the structure of the home, including subsequent collapse, and ruining many of the homeowner's contents. The homeowner was displaced from her home as the house became uninhabitable. A claim was filed with the homeowner's insurance company and the insurance company assigned an adjuster to the claim. Eventually, the insurance company paid the insured homeowner approximately $250,000 on the loss and refused to renew the insured's policy. Unsatisfied, the insured retained our services.

Through experts we established that the insurance company's valuation of the claim was woefully inadequate.

But equally important, we established improprieties in the claims handling process. It was the insurance company's adjuster that referred a general contractor and a public adjuster to the insured. The insurance company's adjuster insisted to the insured, a single mother who was in the midst of a divorce, that this was the only way to resolve the claim. We demonstrated that the contractor and the public adjuster were siblings and associates of the insurance company adjuster. This trio went about a conspiracy to defraud the insured in an attempt to quickly benefit themselves and the insurance company. Not only was the claim negligently handled by this trio but they charged excessive fees and extorted the insured. Toward the end of the trio's involvement, the contractor and public adjuster demanded that the insurance company adjuster be paid $18,000 by the insured for any more monies to be paid on the claim.
In the face of the above evidence, the insurance company settled the case for an additional $587,500.

$302,500 RECOVERY ON 10 YEAR OLD PLUS CLAIMS FOR HOMESTEAD LUMBER YARD

We were retained in 2010 by the owner of a Homestead business with pending insurance claims lawsuits stemming from tornado and hurricane losses going back, respectively, to January 2, 2002 and October 15, 1999.

Prior to our representation, our client had two prior lawyers represent him, at different times. He also had consultants and public adjusters represent him in these claims. Because his claims went back so many years, his claims needed to be reconstructed. Many records, including certain court documents, were missing. The client did not have a complete copy of his cases or of records supporting his claims or damages. The prior lawyers provided us with incomplete records.

Our client had a history of losses and insurance claims that pre-existed the two claims that we were retained on. The same insurance company adjuster that worked on the prior claims was assigned to the subject claims. This adjuster prepared detailed reports with pictures after each loss. These reports were very injurious to the subject claims because they indicated that repairs to the business were not made after payment on the prior claims. The pictures taken right after the prior claims showed damage nearly identical to the pictures taken after the subject claims.

Therefore, the insurance company argued that our client was perpetrating a fraud. The defense of fraud was bolstered by our client's own public adjuster. A few days after the tornado loss, the public adjuster and the insurance company's field adjuster met at the client's business to inspect the damages caused by the tornado. The insurance company's adjuster showed the public adjuster pictures that he had taken in 1998, for purposes of adjusting the prior loss. While they were looking at these pictures, they were simultaneously looking at the premises, including the on-site structures, contents, and the like. Following such, the public adjuster opined that the damages looked almost identical to how they looked in 1998. Later the public adjuster withdrew from representation and testified in deposition that he believed the claim to be fraudulent.

$302,500 RECOVERY ON 10 YEAR OLD PLUS CLAIMS FOR HOMESTEAD LUMBER YARD (CONT.)

There was very little evidence that the damages from the prior claims had been repaired prior to the subject claims. In spite of the above challenges we were able to get the case settled after two mediations for $302,500.

$283,644.20 POLICY LIMITS RECOVERY FOR DAMAGES TO CONDO UNIT

Our client, the owner of a multimillion dollar condominium unit on the beach, suffered substantial damages to his master bathroom as a result of a plumbing failure. He notified his insurance carrier promptly of the loss. And he mitigated his damages by hiring a plumber to make temporary repairs to the failed plumbing line. However, the insurance company stonewalled payment to our client under the guise of investigating its subrogation rights against the plumbing company that it believed was the culprit for the plumbing failure. The client's business attorney and insurance agent referred the claim to our office when the insurance company requested an examination under oath. We promptly made a demand for the policy limits to the insurance carrier, filed a Civil Remedy Notice of Insurer Violation with the Florida Department of Financial Services, and prepared the policyholder for the examination under oath and attended the examination under oath with the policyholder. Shortly after the examination under oath we filed a lawsuit against the insurance company. The insurance company tendered the policy limits shortly after the lawsuit was filed.

$200,000 RECOVERY FOR BUSINESS DAMAGED BY FIRE SPRINKLER

Our clients in this case are owners of a large import-export company in Miami. On the day in question, our clients' arrived at their office to discover that the indoor sprinkler system had gone off during the night resulting in substantial damage to the warehouse and inventory. They promptly filed a claim with their insurance carrier. The insurance carrier began its investigation which concluded with an inadequate damages valuation. Our clients retained us to assist in this claim. We immediately retained the necessary experts and armed with these opinions we were able to negotiate a recovery of multiple times the insurance company's valuation of the loss.

SIX FIGURE RECOVERY FOR DRAIN LINE DAMAGE

The homeowner suffered property damage to her Miami Springs home as a result of a plumbing break in a drain line in 2010. She reported the claim to her insurance company. The insurance company inspected the home and sent the homeowner a claims payment for a little over $1,000.

We were not retained until March, 2013. Prior to our representation, our client had filed a lawsuit over the claim with another lawyer. She also had consultants and a public adjuster represent her in the claim. The client retained our services after she had a falling out with her lawyer and public adjuster over, among other things, the value of the claim. The public adjuster had prepared an estimate of damages for approximately $37,000.

We retained our own expert on damages and conducted depositions and discovery. One week prior to the commencement of trial and less than one year after being retained in the case, we were able to secure a six figure settlement for our client.

$100,000 RECOVERY FOR FIRE LOSS AT COFFEE PACKING PLANT

In this case, our client owned a small coffee packing plant. The plant was damaged as a result of a fire. The fire also damaged a company truck and a personal vehicle. Our client retained a public adjuster. Claims were filed with the two relevant insurance companies. Both insurance companies where involved in an arson investigation of the claims. Shortly after it became clear that the claims process was becoming adversarial, our client retained our firm. The insurance companies retained experts and

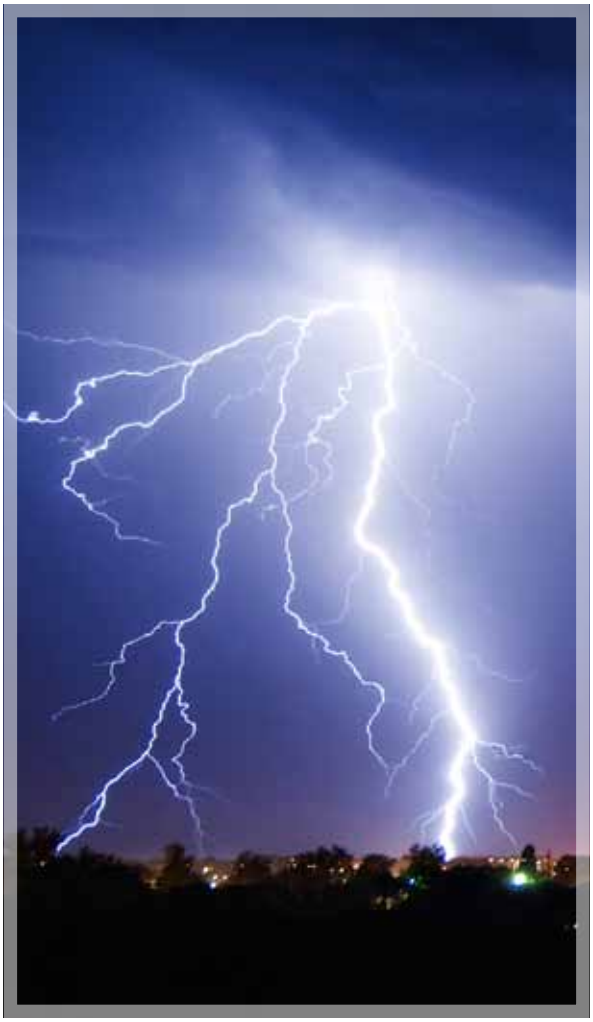
conducted examinations under oath. With the help of our own experts, we succeeded in convincing the insurance companies to extend coverage for the loss.

RECOVERY FOR 45 TIMES OVER INSURANCE COMPANY'S ORIGINAL PAYMENT ON KITCHEN FIRE CLAIM

Our clients, the policyholders, suffered a kitchen fire to their home as a result of a frying pan catching on fire. The fire generated mostly smoke. There was minimal damage caused by the actual flames. Most of the damage was caused by the smoke. This is an important distinction because the photographs taken of the damage shortly after the loss did not present strong visual evidence of the damage. Our clients notified the insurance company promptly after the loss. The policyholders did not retain any professional assistance immediately after the loss. The fire department was never called out to the loss. The insurance company sent out a field adjuster to the home who inspected and photographed the loss and issued a check for $1,200. Not satisfied with this nominal payment, the policyholders sought out our assistance upon the recommendation of a prior firm client. We immediately filed suit. Among the depositions that we took was the deposition of the field adjuster. In that deposition we established that the field adjuster was not qualified to inspect a smoke damaged home. We retained a general contractor and a fire damage expert. Through these experts we established that the home suffered substantial smoke damage that is not visible in photographs. The case settled shortly before trial for over 45 times the amount of the original payment made by the insurance company.

LIGHTNING STRIKE LEADS TO BUSINESS INTERRUPTION

Our client in this case is a local Miami business which incurred property damage to its business equipment as a result of a lightning strike interrupting its business operations for days.
The insurance carrier lowballed the insured with its claims offer. The insured consulted its business lawyer regarding this matter who in turn referred the case to our offices. Immediately after being retained, we sent out a consultant to evaluate the damages to the business as a result of the lightning strike. Thereafter, we prepared a demand to the insurance carrier for the true value of the claim. For all intents and purpose, the insurance carrier ignored our demand. We thereafter filed a lawsuit against the insurance carrier and we filed a Civil Remedy Notice of Insurer Violation with the Florida Department of Financial Services. After commencement of litigation, we were able to settle the claim at mediation.



LIFE, DISABILITY, HEALTH, HMO INSURANCE CLAIMS

REPRESENTATIVE CASES

We have handled many life insurance claims, long term disability insurance claims, and health insurance/HMO claims. Many of the life insurance claims that we have handled concern application issues raised by the insurance company during the two year contestability period. We have also litigated interpleader actions where multiple individuals claim to be the proper beneficiary, fraud issues, forgery issues related to change of beneficiary documents, and other issues. In the long term disability insurance claims arena we have represented physicians, nurses, county employees, and other professionals with disabilities ranging from fibromyalgia, multiple sclerosis, mental disorders, orthopedic, and neurological deficits. We have also represented many individuals with individual or non-ERISA insurance policies when they have a claim denied. Below is a sampling of some of our more interesting cases.

SIX FIGURE RECOVERY ON "MISSING" LIFE INSURANCE POLICY

Our client's husband unexpectedly passed away leaving a five year old son. At the time of his death, our client's husband carried a life insurance policy through his employer, leaving his son as the primary beneficiary and his wife as secondary beneficiary. Shortly after the death, our client and her family notified the employer and life insurance company about the tragedy. One and half years later, our client had not yet received one cent from the life insurance company. As a single working mom of a young boy she suffered not only from the death of her husband but from her financial situation. She retained our office. Clearly, our client had become a victim of an insurance company that subjected her to a complete run-around. Shortly after we became involved, we persuaded the insurance company to set aside many of the issues that they were claiming existed prior to our representation. Prior to our involvement, the insurance company had initially taken the position that no insurance policy even existed. Shortly after we became involved, we were able to prove that an insurance policy did indeed exist. Thereafter, the insurance company took the position that although a policy existed, the face amount of the policy was only $10,000. We proved that the husband had elected to purchase a supplemental policy for an additional $100,000. Eventually, the case was resolved for the full and correct policy limits. A guardianship was established for the minor. We continued to represent our client and her son in guardianship proceedings on a pro bono basis.

SIX FIGURE POLICY LIMITS RECOVERY ON LIFE INSURANCE POLICY

The policyholder purchased a life insurance policy on July 29. On the application for insurance the policyholder disclosed that he suffered from high blood pressure but denied any other health problems. Unfortunately, on October 1 of the same year, the policyholder died of a heart attack leaving behind a son and wife. The wife was the sole beneficiary on the insurance policy. Because the policyholder died during the two year contestability period, the insurance company proceeded to perform a post-claims underwriting investigation. To that end, the insurance company ordered all of the policyholder's medical records. Based on the medical records, the

insurance company took the position that the policyholder failed to disclose on the application for insurance that he was being followed for hypertensive cardiovascular disease. The insurance company denied the claim asserting that if it had known this information at the time that the policyholder applied for insurance it would not have sold him the policy. The policyholder appealed this decision. The insurance company once again denied the claim. The beneficiary then retained our services. After reviewing the application for insurance and the medical records, we proceeded to interview the policyholder's primary care physician to get a better understanding of the policyholder's medical condition at the time that he applied for insurance. As a result of this interview, we were able to establish that the medical conditions that the insurance company claimed were not disclosed on the application for insurance fell under the umbrella of the policyholder's high blood pressure disease, which he had disclosed on the application for insurance. We used this fact along with the language in the application for insurance that required the policyholder to answer the questions on the application only to the best of his knowledge and belief (and supporting case law) to convince the insurance company to reverse its denial of the claim without the need for litigation which resulted in securing the life insurance benefits, plus interest.

LIFE INSURANCE COMPANY CONDUCTS POST-CLAIMS UNDERWRITING AFTER DEATH OF MOTHER

Our client was the beneficiary under a life insurance policy that covered his mother. Unfortunately, his mother passed away unexpectedly. Because the deceased passed away within the first two years of the inception of the life insurance policy, the insurance carrier conducted a post-claims underwriting investigation. This means that the insurance carrier, essentially, began investigating whether the insured made any "misrepresentations" on the insurance application when she purchased the policy. This resulted in the insurance carrier's voluminous requests for the insured's medical history. After months of investigating and receiving no final decision on the claim, the beneficiary contacted our office. On behalf of the beneficiary we filed a Civil Remedy Notice of Insurer Violation with the Florida Department of Financial Services. We also communicated with the insurance carrier and demanded that the policy limits be paid immediately. Shortly after we became involved, the insurance company tendered the policy limits to the beneficiary.

$167,800.48 RECOVERY UNDER AN ACCIDENTAL DEATH BENEFIT RIDER FOR MURDERED POLICYHOLDER

In this case, the policyholder died of multiple gunshot wounds at the hands of an assailant. At the time of his death, the policyholder owned a life insurance policy that contained an Accidental Death Benefit Rider. The death occurred during the two year contestability period of the insurance policy. The beneficiary under the insurance policy filed a claim under the policy. Initially, the insurance company engaged in a post-claims underwriting investigation of the claim, as is customary for insurance companies. When that investigation did not reveal any basis for denial of the claim, the insurance company claimed that it was investigating whether the death of the policyholder was "accidental". The focus of the insurance company's investigation was whether the policyholder's conduct contributed to his death so as to make his death reasonably foreseeable, and thus, in the insurance company's world, not accidental. This is when the beneficiary contracted our services. Since the assailant was arrested and charged with the murder of the policyholder, we made contact with the detective investigating the case. We also made a public records

request for the records related to the investigation of the crime in the possession of the prosecuting authority. We were then able to piece together the events leading to the murder. We showed that the policyholder was strictly a victim of a crime and not involved in the commission of any crime himself. A recovery of the full benefits available under the insurance policy was made, plus interest.

RECOVERY OF LONG TERM DISABILTY BENEFITS FOR "DRUG ADDICT" DIAGNOSED WITH FIBROMYALGIA

In this case, our client was a former insurance company employee who purchased an individual long term disability insurance policy through her insurance company employer. Thereafter, she began to experience a host of painful medical symptoms that according to her insurance company were "vague". Eventually, the insured was diagnosed with fibromyalgia. Fibromyalgia is a controversial disease characterized by widespread musculoskeletal pain. Treatment of fibromyalgia often includes the use of pain medications. The insured's primary care physician was a rheumatologist and pain management doctor that placed her on a regimen of pain medications. As a result of the illness and treatment regimen the insured claimed that she could not work. The insurance company met the insured's "vague" complaints with a "vague" denial letter. We filed a lawsuit in state court that was removed to federal court. In the discovery phase of the case we learned that the insurance company's denial of the claim was premised on its belief that the insured was a run of the mill pain medication addict. To bolster this argument the insurance company attempted to demonstrate that the insured's husband was also a patient of the same rheumatologist and pain management doctor and was being prescribed the same pain medications. Eventually, the insured's husband passed away of an alleged drug overdose. After significant litigation, we were able to get the case favorably settled at mediation.

INSURED FORCED TO SUE HMO TWICE BECAUSE OF SAME CONDUCT

Our client was insured under an HMO policy. The insured suffered from Multiple Sclerosis. As a result of the Multiple Sclerosis, the insured is prescribed the medication Copaxone. The HMO paid for the prescription on a monthly basis; however, the HMO would unilaterally decide to stop honoring payments for the drug from time to time. The first time that the HMO refused to honor the cost of the medication, the insured retained our services. In spite of our pre-suit requests that the HMO pay for the medication, the HMO refused to honor the cost of the medication. We filed suit on behalf of the insured in state court. The HMO removed the case to federal court claiming that there was a federal question involving certain Medicare regulations that would have to be construed in reaching a ruling on the dispositive issues in the case. Discovery commenced in the case. Thereafter, we filed a motion to remand the case back to state court when it became clear that there was no federal question involved and that Medicare regulations did not have to be construed for the purpose of reaching a decision on the contractual issue in the case. While our motion for remand was pending, the HMO agreed to pay the full amount of the claim plus attorney fees and costs. A few years later after the resolution of this claim, the HMO again unilaterally made a decision to stop honoring the insured's necessary medication for Multiple Sclerosis. Again, we filed suit in state court after the HMO refused our pre-suit demands to pay for the medication. After a lawsuit was commenced, the HMO was again required to honor the cost of the medication along with payment of the insured's out of pocket expenses including attorney fees and cost.

HMO COVERAGE FOR LIVER TRANSPLANT

Our client in this case was a 56 year old woman who came to our office when she received a letter from her HMO carrier denying pre-transplant and transplant services for a liver transplant. The reason given for the denial was that the benefit plan excluded prescription medication coverage and without prescription medication coverage she would not be able to have the transplant. Our office immediately filed suit arguing that although the plan did not cover prescription medication coverage, such coverage was not a condition precedent to coverage for pre-transplant services. At the time of the denial, our client was already in the middle of the pre-transplant testing. After the commencement of litigation, we were able to convince the HMO of our position and the pre-transplant testing was approved. The case was dismissed and the insurance company paid our client's attorney fees. Unbelievably, after our client was approved for the liver transplant after all of the pre-transplant testing was completed the HMO again suspended the actual liver transplant based on the same exclusion. We once again filed suit.

The HMO carrier once again lifted the suspension after litigation was commenced and was required by the court to pay our client's attorney's fees and costs. Fortunately, our client was finally approved for the liver transplant.
We have handled many insurance claims concerning the theft or damage to automobiles, boats, motorcycles, and jet skis concern application issues raised by the insurance company, fraud, appraisal issues, valuation issues, and other coverage issues. Below is a sampling of some of our more interesting cases.

MOTOR VEHICLE AND BOAT INSURANCE CLAIMS

REPRESENTATIVE CASES

SETTLEMENT FOR LOSS OF ROLLS ROYCE PHANTOM

Our client's Rolls Royce Phantom was totaled while being driven by a friend. Our client filed a claim with his insurance carrier. Our client cooperated fully and to the best of his ability with the insurance company's investigation of the claim, including submitting himself to several statements taken by the insurance carrier and its lawyers, prior to our representation of the client. The insurance carrier's investigation focused on whether the insured was engaged in fraud and whether the vehicle was being used for non-covered business purposes. Almost 10 months after the loss and with the insurance carrier still claiming that the file was under "investigation", the client's then lawyer filed a lawsuit against the insurance carrier. Only then did the insurance carrier send a letter denying the subject claim. Shortly into the litigation, the client's then lawyer withdrew his representation of the insured. The client then retained our services. Within a few months of our involvement in the case, we recovered the full value of the Rolls Royce plus attorney's fees and costs from the insurance carrier and we brokered retention of valuable salvage rights over the Rolls Royce for the client.

INSURANCE CLAIM IS DENIED BECAUSE OF CONDUCT OF BODY SHOP

Our client, the insured under a comprehensive automobile insurance policy, suffered the theft of her vehicle. Fortunately, the vehicle was recovered within a few days with minor damage to the vehicle incurred as a result of the theft. Our client took the vehicle to a local body shop for repairs and contacted her insurance company. The body shop prepared an estimate of the repairs deemed necessary as a result of the theft. The insurance company sent out an appraiser to inspect the vehicle at the body shop. All of the dealings regarding damages to the vehicle took place between the body shop and the insurance company's appraiser and adjuster. The insurance company subsequently denied the insured's claim. As the basis for the denial, the insurance company claimed that the body shop had intentionally inflicted additional damage to the vehicle in order to inflate the cost of the repairs. However, the insurance company proffered no evidence that the insured had any involvement with the body shop's claimed actions. Although repeated requests were made during pre-suit and litigation for the insurance carrier to honor the insurance claim for those damages that were undisputedly related to the theft, the insurance company continued to deny the whole claim. Even though there was no evidence that the insured had anything to do with the body shop's claimed conduct, the insurance company continued to punish the insured as opposed to prosecuting its complaints against the body shop. As a result, the case moved forward to trial. Just before trial was to begin, the insurance company settled the insured's claims for the damage to the vehicle, bad faith damages, attorney fees, and the costs incurred by the insured in prosecuting her claim.

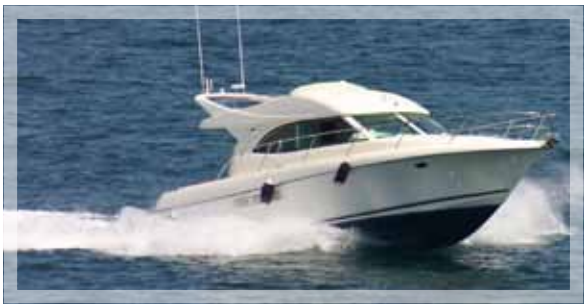
INSURANCE CLAIM RECOVERY FOR THEFT OF BMW

Our client's BMW was stolen and not recovered. Our client, who was insured for the loss under an automobile insurance policy with a national insurance company, filed a claim with her insurance carrier requesting payment

under the policy for the value of the lost vehicle. The insurance company referred the claim to its Special Investigative Unit (SIU) for investigation. The SIU adjuster took statements from the insured and her family members, obtained extensive records from the insured, obtained the keys of the vehicle from the insured, and ultimately the claim was denied. The insurance company alleged that the insured made misrepresentations during the claims process and submitted a fraudulent claim. Upon denial of the claim, the insured retained our services. Litigation commenced. The insurance company made numerous allegations of wrongful conduct on the part of the insured, which we disproved. But the insurance company focused its defense primarily on its "expert's" reading of the electronic information contained in the car keys. The insured had testified that she had driven her car on the day of the theft to a local mall where the vehicle was stolen from. According to the expert's key readings, the vehicle was not driven on the day that the insured testified that the car was stolen. With the help of our expert on Auto Thefts and Keys and the testimony from a BMW representative we successfully proved that the subject key readings were unreliable. In addition, at the deposition of the SIU adjuster we obtained an admission from the adjuster that she recommended to the insurance carrier that the claim be honored, which recommendation was rejected by her supervisor. On the day prior to the start of trial the insurance company confessed judgment by paying the full value of the stolen BMW, compensating the insured for her inconvenience, and by paying all litigations costs and attorney's fees incurred by the insured.

SIX FIGURE RECOVERY ON STOLEN BOAT INSURANCE CLAIM IN FEDERAL COURT

In this case, our client had a boat stolen from his home. The insured routinely parked the boat at his home behind a locked gate. One morning the insured woke up and the boat was missing. He reported the disappearance of his boat promptly to the police and the insurance company. The insured had a security system installed at his home which included exterior cameras in the area of the home where the boat was parked. In spite of the cameras, the insured was unable to find footage for the area where the boat was parked on the day in question. The insurance company conducted an "investigation" which included inspecting the home, taking statements from the insured and his family, and requesting numerous records from the insured. At the conclusion of this investigation, the insurance company refused to pay the claim citing a number of "red flags", including the insurance company's position



that it did not find any evidence of forced entry into the area where the boat was parked, possible financial difficulties that the insured was experiencing, and the "missing" video. We were retained at this point. We filed a lawsuit in state court which the insurance company removed to federal court. We conducted our own investigation which discovered bite marks on the locking mechanism to the gate consistent with forced entry into the yard. We demonstrated that any financial issues were not relevant to the claim in that the insured was always timely on his boat loan payments. And lastly, we discovered the video footage of the actual theft which showed two men breaking into the yard and stealing the boat. The case settled shortly thereafter. The boat was never recovered.

NOTES

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