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

9700695 -

DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 96-24937-00-039

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 4 | 4 | 0 | 5 | 0 |
 (See Table A)

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

3a. HEALTH CARE PROVIDER: PARIKH, SONAL BHARAT
 (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: 10 | 0 | 4 | 7 | 6 | 3 | 5 |

3c. INSURED'S NAME: SONAL B. PARIKH, MD

STREET ADDRESS: 5596 WEST NORVELL BRYANT HWY

CITY: CRYSTAL RIVER STATE: F | L ZIP: 3 | 4 | 4 | 2 | 9 COUNTY CODE: 4 | 7
 (See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>1005170</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 (02) No (If yes, enter the Country
 in which primary medical education was received: INDIA IND

6. PROFESSION OR BUSINESS: (Check One)

<input checked="" type="checkbox"/> (01) Physicians & Surgeons	<input type="checkbox"/> (04) Dentist	<input type="checkbox"/> (07) Crisis Stabilization Unit
<input type="checkbox"/> (02) Hospitals	<input type="checkbox"/> (05) Abortion Clinics	<input type="checkbox"/> (08) Health Maintenance
<input type="checkbox"/> (03) Podiatrists	<input type="checkbox"/> (06) Ambulatory Surgical Centers	Organization

7. SPECIALTY CODE: 8 | 0 | 2 | 4 | 9 | (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: _____

(04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check One)

<input type="checkbox"/> (01) Hospital Inpatient Facility	<input type="checkbox"/> (04) Nursing Home	<input type="checkbox"/> (07) Other Outpatient Facility
<input type="checkbox"/> (02) Emergency Room	<input checked="" type="checkbox"/> (05) Physician's Office	<input type="checkbox"/> (08) Other Location
<input type="checkbox"/> (03) Hospital Outpatient Facility	<input type="checkbox"/> (06) Patient's Home	<input type="checkbox"/> (09) Other Hospital/Institution

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY
 OCCURRED: N/A

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11. NAME OF INSTITUTION: N/A INSTITUTION CODE:

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 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One) N/A

<input type="checkbox"/> (01) Patient's Room	<input type="checkbox"/> (05) Physical Therapy Dept.	<input type="checkbox"/> (09) Radiology
<input type="checkbox"/> (02) Operating Suite	<input type="checkbox"/> (06) Nursery	<input type="checkbox"/> (10) Emergency Room
<input type="checkbox"/> (03) Recovery Room	<input type="checkbox"/> (07) Critical Care Unit	<input type="checkbox"/> (11) Other: _____
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 11/15/94
 DATE REPORTED TO INSURER: 08/14/96

14. INJURED PERSON'S AGE: 36 Years (If less than one year, enter 00; if unknown, enter UNK.)
 INJURED PERSON'S SEX: (M) F (Circle One)

14.1 INJURED PERSON'S NAME: _____
Last Name First and Middle Initial

STREET ADDRESS: _____

CITY: _____ ZIP: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>Insomnia.</u>	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>None.</u>	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>N/A</u>	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: <u>Ongoing psychiatric treatment and treatment for insomnia.</u>	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: <u>36 year old male with chronic paranoid schizophrenia brought pro se claim against Member for alleged conspiracy. Dismissed by Court.</u>	19.

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20. SEVERITY OF INJURY: (Check only one - rate most serious injury if several are involved.)

- (01) Emotional only - Fright, no physical damage.
- (02) Insignificant--- Lacerations, contusions, minor scars, rash. No delay.
- Temp- (03) Minor----- Infections, 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: 8/14/96

21.1 CIRCUIT COURT CASE NUMBER: 96-2279-CA

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 4 | 7 (SEE TABLE B)

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

	<u>DEFENDANT'S NAME (Last Name, First Name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE ID.</u>
1)	<u>N/A</u>	<u> </u>	<u> </u>
2)	<u> </u>	<u> </u>	<u> </u>
3)	<u> </u>	<u> </u>	<u> </u>
4)	<u> </u>	<u> </u>	<u> </u>
5)	<u> </u>	<u> </u>	<u> </u>

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

24. DATE OF FINAL CLAIM DISPOSITION: 3/17/97

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-judgement relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claim or suit abandoned.

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27. COURT: (Check One)

<input type="checkbox"/> (01) No court proceedings. <input type="checkbox"/> (02) Directed verdict for plaintiff. <input type="checkbox"/> (03) Directed verdict for defendant. <input type="checkbox"/> (04) Judgement notwithstanding the verdict for plaintiff. <input type="checkbox"/> (05) Judgement notwithstanding the verdict for defendant. <input type="checkbox"/> (06) Judgement for the plaintiff.	<input type="checkbox"/> (07) Judgement for the defendant. <input type="checkbox"/> (08) Judgement for the plaintiff after appeal. <input type="checkbox"/> (09) Judgement for the defendant after appeal. <input checked="" type="checkbox"/> (10) Other <input type="checkbox"/> (11) Summary judgement for the plaintiff. <input type="checkbox"/> (12) Summary judgement for the defendant.
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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.
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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: \$ 5,720.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: \$ 286.00

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: \$ 0.00

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: N/A

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 INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Member has discussed case with insurance company personnel and defense counsel.

CONTACT PERSON: Beth Rominger
TELEPHONE: (813) 933-8517

ADDRESS: Physicians Protective Trust Fund
2901 W. Busch Blvd., Suite 503
Tampa, Florida 33618