

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

FILE# _____

PRIMARY CARRIER

Company Code 01470 (Florida Certificate of Authority Number)

Company Name The St. Paul Companies

Policy Number 509 JH 8712 (09C-001)

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 85 FCC MMI IAC 3

Insured Ignacio S. Pantalone M.D.

Address 11300 U.S. 19 S.; Clearwater, FL 33516 County Code 04

(1) Surgery Code 13 Speciality Psychiatry Code 19

(2) Date of Incident (Month, Day Year) 101382

(3) Date submitted for mediation (Month, Day, Year)

(4) Disposition of mediation (check one):

(1) Plaintiff (2) Defendant (3) No final conclusion

(5) Date of suit, if filed (Month, Day, Year) 030784

(6) Disposition of incident (check one):

(1) Final Judgment (2) Settlement

(3) Final Disposition Not Resulting in Payment on Behalf of the Insured

(7) Date and amount of Judgment or Settlement (Month, Day, Year) 091685

A. Primary Indemnity \$ 50000 C. Excess Indemnity \$ _____

B. Primary Defense \$ 9594 D. Excess Defense Costs \$ _____

(8) Summary Judgment (1) For Plaintiff (2) For Defendant

(9) Directed Verdict (1) For Plaintiff (2) For Defendant

(10) Trial (1) YES (2) NO

(11) Date and reason for final disposition, if no settlement or judgment:

(Month, Day, Year)

(12) Include brief summary of occurrence which created claim on back.

Insured released the patient from mental facility - patient committed suicide the next day.