

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

DEC 4 1997

9702853

DEPT. FILE NO.

BUREAU OF PROPERTY  
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 95-22237-04-041

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: PANLILIO, ROMEO LADISLAO  
(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: 0 | 0 | 4 | 0 | 1 | 6 | 8 |
- 3c. INSURED'S NAME: ROMEO L. PANLILIO, MD  
STREET ADDRESS: C/O OSCEOLA REGIONAL HOSPITAL, 700 WEST OAK STREET  
CITY: KISSIMMEE STATE: F | L ZIP: 3 | 2 | 7 | 4 | 1 COUNTY CODE: 2 | 6  
(See Table B)
- |                  | POLICY NUMBER  | PER CLAIM POLICY LIMITS | AGGREGATE POLICY LIMITS |
|------------------|----------------|-------------------------|-------------------------|
| PRIMARY INSURER: | <u>1005184</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: PHILIPPINES PK
6. PROFESSION OR BUSINESS: (Check One)  
 (01) Physicians & Surgeons  (04) Dentist  (07) Crisis Stabilization Unit  
 (02) Hospitals  (05) Abortion Clinics  (08) Health Maintenance  
 (03) Podiatrists  (06) Ambulatory Surgical Centers  Organization
7. SPECIALTY CODE: 8 | 0 | 2 | 8 | 0 (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)  
 (01) Hospital Inpatient Facility  (04) Nursing Home  (07) Other Outpatient Facility  
 (02) Emergency Room  (05) Physician's Office  (08) Other Location  
 (03) Hospital Outpatient Facility  (06) Patient's Home  (09) Other Hospital/Institution
10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY  
OCCURRED: N/A

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

11. NAME OF INSTITUTION: OSCEOLA REGIONAL HOSPITAL INSTITUTION CODE: 1 | 0 | 0 | 1 | 1 | 0  
 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

<input type="checkbox"/> (01) Patient's Room	<input type="checkbox"/> (05) Physical Therapy Dept.	<input checked="" 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: 01/12/93

DATE REPORTED TO INSURER: 01/13/95

14. INJURED PERSON'S AGE: 52 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: (M)  (F)  (Other)

14.1 INJURED PERSON'S NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Sick sinus syndrome. (LEAVE BLANK)  
 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: N/A  
 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: An X-ray following pacemaker placement was interpreted as showing an interrupted lead which was eventually determined to be a guide wire.  
 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: X-ray interpretation.  
 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: Allergic reaction to guide wire.  
 19.



FLORIDA DEPARTMENT OF INSURANCE  
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27. COURT: (Check One)

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

28. ARBITRATION: (Check one)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.<br><input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.<br><input type="checkbox"/> (04) Award for defendant. |
|--|--|

29. WAS THERE AN ITEMIZED VERDICT? (Check One)

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

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . \$ 25,000.00

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: . . . . . \$ 28,560.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: . . . . . \$ 9,086.00

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: . . . . . \$ 25,000.00

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 |                |

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

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, medical experts 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