The St Paul

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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

Amended Report attached

DEPARTMENT FILE NO. 8704091

INSURER'S CLAIM NO. 509JN5116 09J001

1. **PRIMARY INSURER NAME:** BUREAU OF ST. PAUL F. + M — **INSURER CODE:** 01470 (See Table A)

2. **EXCESS INSURER NAME:** 0 — **INSURER CODE:** (See Table A)

3. **INSURED'S NAME:** PANLILIO, ROMEO L. [redacted]
(Last Name, First and Middle Name)

STREET ADDRESS: 1410 RIVIERA DR.

CITY, STATE: KISSIMMEE, FL ZIP: 32741 COUNTY CODE: 26 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	509JN5116	$ 1 MIL .00	$ 3 MIL .00
EXCESS INSURER:	0	$ 0	$ 0

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 (PH)

6. **PROFESSION OR BUSINESS:** (Check one)
✓ (01) Physicians & Surgeons
___ (02) Hospitals
___ (03) Podiatrists
___ (04) Other Medical Professionals
___ (05) Clinics
___ (06) Ambulatory Surgical Centers
___ (07) Other Health Care Facilities

7. **SPECIALTY CODE:** 80280 (See Table C) (Applies to physicians, surgeons, and other health care professionals. 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 specialty. Enter the additional specialty code here: ____ (Table C)
___ (04) Insured is not board certified.

9. **PLACE WHERE INJURY OCCURRED:** (Check one)
✓ (01) Hospital Inpatient Facility
___ (02) Emergency Room
___ (03) Hospital Outpatient Facility
___ (04) Nursing Home
___ (05) Physician's Office
___ (06) Patient's Home
___ (07) Other Outpatient Facility
___ (08) Other Location
___ (09) Other Hospital/Institution

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: ____

11. NAME OF INSTITUTION: HUMANA, KISSIMMEE — **INSTITUTION CODE:** 100110 (See Table D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)
___ (01) Patient's Room
___ (02) Operating Suite
___ (03) Recovery Room
___ (04) Labor & Delivery Room
___ (05) Physical Therapy Dept.
___ (06) Nursery
___ (07) Critical Care Unit
___ (08) Special Procedure Room
✓ (09) Radiology
___ (10) Emergency Room

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

13. **DATE OF OCCURRENCE:** 6/21/84

DATE REPORTED TO INSURER: 5/13/85

14. **INJURED PERSON'S AGE:** 73 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (M) F (Circle one)

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

		(LEAVE BLANK)
15.	FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: LEFT BODY WEAKNESS, SLURRED SPEECH STROKE	15.
16.	DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NONE	16.
17.	DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: QUESTION OF PROPRIETY OF ANGIOGRAM	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: INSD PERF. ANGIOGRAM PT SUFFERED 2ND STROKE	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: PER # 18	19.

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, misset 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----------Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
___ (09) Death

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 509 JN 5116 09J001

21. **DATE OF SUIT, IF ANY:** 5/6/85

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

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	NONE		
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN **ATTORNEY?** (Check one)
✓ (01) Yes ___(02) No

24. **DATE OF FINAL CLAIM DISPOSITION:** ~~11/5/85~~ 7/14/87 See attached

25. **FINAL METHOD OF CLAIM DISPOSITION:**
___(01) Settled by parties.
✓ (02) Disposed of by a court.
___(03) Disposed of by arbitration.

26. **SETTLEMENT:** (Check one)
___(01) Within the presuit period as set forth in Seciton 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 is filed and prior to or during the course of mandatory settlement conference.
___(05) Prior to completion of the swearing of the jury.
___(06) Prior to filing of the notice of appeal.
___(07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___(08) During appeal.
___(09) After appeal.
___(10) Claim or suit abandoned.

27. **COURT:** (Check one)
___(01) No court proceedings.
___(02) Directed verdict for plaintiff.
___(03) Directed verdict for defendant.
___(04) Judgment notwithstanding the verdict for the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after appeal.
✓ (09) Judgment for the defendant after appeal.
___(10) Other
___(11) Summary judgment for the plaintiff.
___(12) Summary judgment for the defendant.

28. **ARBITRATION:** (Check one)
✓ (01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. WAS THERE AN ITEMIZED **VERDICT** UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes ✓ (02) No (If yes, please attach copy of settlement or verdict.)

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

30. INDEMNITY PAID BY YOU ON BEHALF OF 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:---- $ 15,577 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:---- $ 610 .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:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	$ 0 .00	$ 0 .00	$ 0 .00
B) ESTIMATED FUTURE	$ .00	$ .00	$ .00

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---- $ 0 .00

B) COST TO THE INSURER OF THE PAYMENTS---- $ 0 .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF---- $ 0 .00

D) DID YOU PURCHASE AN **ANNUITY?** ___(01) Yes ✓(02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: NA

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: unknown

CONTACT PERSON: Evelyn M. Wiley ADDRESS _____
TELEPHONE: ( ) 305-660-2700

ST- PAUL FIRE & MARINE INS. CO.
ORLANDO SERVICE CENTER
1060 MAITLAND CENTER COMMONS BLVD.
MAITLAND, FLORIDA 32751

The Straub POST MARKED PREVIOUSLY REPORTED

JAN 12 1988

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

AMENDED REPORT

9704091

DEPARTMENT FILE NO. _____

INSURER'S CLAIM NO. 509 JN 5116 09J001

BUREAU OF RATES

1. **PRIMARY INSURER NAME:** ST. PAUL F. + M **INSURER CODE:** 0 1 1 4 7 0 (See Table A)

2. **EXCESS INSURER NAME:** 0 **INSURER CODE:** _____ (See Table A)

3. **INSURED'S NAME:** PANZILIO, ROMEO L. (Last Name, First and Middle Name)

STREET ADDRESS: 1410 RIVIERA DR.

CITY, STATE: KISSIMMEE, FL. ZIP 32741 **COUNTY CODE:** 2 6 (See Table B)

SEE PAGE 3.

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	_____	$ _____ .00	$ _____ .00
EXCESS INSURER:	_____	$ _____	$ _____

5. Is the insured physician a **Foreign Medical Graduate?**
___ (01) Yes
___ (02) No

If yes, enter the **country** in which primary medical education was received: _____

6. **PROFESSION OR BUSINESS:** (Check one)
___ (01) Physicians & Surgeons
___ (02) Hospitals
___ (03) Podiatrists
___ (04) Other Medical Professionals
___ (05) Clinics
___ (06) Ambulatory Surgical Centers
___ (07) Other Health Care Facilities

7. **SPECIALTY CODE:** _____ (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. **BOARD CERTIFICATION:** (Check one)
___ (01) In specialty coded in Item 7, above.
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___ (04) Insured is not board certified.

9. **PLACE WHERE INJURY OCCURRED:** (Check one)
___ (01) Hospital Inpatient Facility
___ (02) Emergency Room
___ (03) Hospital Outpatient Facility
___ (04) Nursing Home
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___ (06) Patient's Home
___ (07) Other Outpatient Facility
___ (08) Other Location
___ (09) Other Hospital/Institution

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: _____ **INSTITUTION CODE:** _____ (See Table D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)
___ (01) Patient's Room
___ (02) Operating Suite
___ (03) Recovery Room
___ (04) Labor & Delivery Room
___ (05) Physical Therapy Dept.
___ (06) Nursery
___ (07) Critical Care Unit
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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

13. **DATE OF OCCURRENCE:** 6/21/84

DATE REPORTED TO INSURER: 5/13/85

14. **INJURED PERSON'S AGE:** 73 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (M) F (Circle one)

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

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:	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:	18.
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___ (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.

Permanent
___ (06) Significant---------Deafness, loss of limb, loss of eye, loss of one kidney or lung.
___ (07) Major----------Paraplegia, blindness, loss of two limbs, brain damage.
___ (08) Grave----------Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
___ (09) Death

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

21. **DATE OF SUIT, IF ANY:** 5/6/85

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

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	NONE		
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN **ATTORNEY?** (Check one)
✓(01) Yes ___(02) No

24. **DATE OF FINAL CLAIM DISPOSITION:** 7/14/87

25. **FINAL METHOD OF CLAIM DISPOSITION:**
___(01) Settled by parties.
✓(02) Disposed of by a court.
___(03) Disposed of by arbitration.

26. **SETTLEMENT:** (Check one)
___(01) Within the presuit period as set forth in Seciton 768.57, Florida Statute (usually within 90 days).
___(02) After arbitration is initiated or prior to suit being filed.
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___(04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
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___(09) After appeal.
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27. **COURT:** (Check one)
___(01) No court proceedings.
___(02) Directed verdict for plaintiff.
___(03) Directed verdict for defendant.
___(04) Judgment notwithstanding the verdict for the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after appeal.
✓(09) Judgment for the defendant after appeal.
___(10) Other
___(11) Summary judgment for the plaintiff.
___(12) Summary judgment for the defendant.

28. **ARBITRATION:** (Check one)
___(01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. WAS THERE AN ITEMIZED **VERDICT** UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes ___(02) No (If yes, please attach copy of settlement or verdict.)

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. _____

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT:----------$ _____ .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT:----------$ _____ .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL:----------$ _____ .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:----------$ _____ .00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE:---------- _____ days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS:---------- _____ days

36. INJURED PERSON'S GROSS WEEKLY INCOME:----------$ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE----------	$ _____ .00	$ _____ .00	$ _____ .00
B) ESTIMATED FUTURE----------	$ _____ .00	$ _____ .00	$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS:----------$ _____ .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS----------$ _____ .00

B) COST TO THE INSURER OF THE PAYMENTS----------$ _____ .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF----------$ _____ .00

D) DID YOU PURCHASE AN **ANNUITY?** ___(01) Yes ___(02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED:_____

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:_____

CONTACT PERSON: Roger M. Wiley ADDRESS _____
TELEPHONE: ( ) 305-660-2700

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