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

9500631
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 94-21438-02-035

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, M.D.

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)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	1005184	$ 1,000,000.00	$ 3,000,000.00
EXCESS INSURER:	N/A	$ 0.00	$ 0.00

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? X (01) Yes ___ (02) No (If yes, enter the Country in which primary medical education was received: PHILIPPINES PH

6. PROFESSION OR BUSINESS: (Check One)

X (01) Physicians & Surgeons
___ (02) Hospitals
___ (03) Podiatrists
___ (04) Dentist
___ (05) Abortion Clinics
___ (06) Ambulatory Surgical Centers
___ (07) Crisis Stabilization Unit
___ (08) Health Maintenance Organization

7. SPECIALTY CODE: 8 0 2 8 0 (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classisification 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: ___ (See Table C)
X (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check One)

___ (01) Hospital Inpatient Facility
X (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 ((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)

___ (01) Patient's Room	___ (05) Physical Therapy Dept.	___ (09) Radiology
___ (02) Operating Suite	___ (06) Nursery	X (10) Emergency Room
___ (03) Recovery Room	___ (07) Critical Care Unit	___ (11) Other: _____
___ (04) Labor & Delivery Room	___ (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 01/13/94

DATE REPORTED TO INSURER: 10/24/94

14. INJURED PERSON'S AGE: 37 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: M

STREET ADDRESS: _

CITY: | 1 |

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Cerebral aneurysm. 15.

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
Patient who was being treated for vascular headache expired following intracranial bleed. Our Member read initial CT as possible bleed.

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.
None.

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: 19.
Death.

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

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

___ (01) Emotional only - Fright, no physical damage.

Temporary
___ (02) Insignificant--- Lacerations, contusions, minor scars, rash. No delay.
___ (03) Minor---------- Infections, missed fracture, fall in hospital. Recovery delayed.
___ (04) Major---------- Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

Permanent
___ (05) Minor---------- Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
___ (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---------- Quadriplegia, severe brain damage, lifelong care of fatal prognosis.

X (09) Death

21. DATE OF SUIT, IF ANY: N/A

21.1 CIRCUIT COURT CASE NUMBER: N/A

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | | | (SEE TABLE B) N/A

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)	Myerson, Daniel A., M.D.	80280	94-21438-01-041
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 3/17/95

25. FINAL METHOD OF CLAIM DISPOSITION:
X (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)
X (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.

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

27. COURT: (Check One)

X	(01) No court proceedings.	___	(07) Judgement for the defendant.
___	(02) Directed verdict for plaintiff.	___	(08) Judgement for the plaintiff after appeal.
___	(03) Directed verdict for defendant.	___	(09) Judgement for the defendant after appeal.
___	(04) Judgement notwithstanding the verdict for plaintiff.	___	(10) Other
___	(05) Judgement notwithstanding the verdict for defendant.	___	(11) Summary judgement for the plaintiff.
___	(06) Judgement for the plaintiff.	___	(12) Summary judgement for the defendant.

28. ARBITRATION: (Check one)

X	(01) Claim not subject to arbitration.	___	(03) Award for plaintiff.
___	(02) Claim subject to arbitration, but settlement reached in lieu of award.	___	(04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT? (Check One)
___ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . $ 525,000.00

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:. . . . . $ 2,149.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:. . . . . $ 11,021.00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: . . . . . 365 days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: . . . . . 3,650 days

36. INJURED PERSON'S GROSS WEEKLY INCOME: . . . . . $ 650.00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE . . .	$ 0.00	$ 34,000.00	$ 4,600.00
B) ESTIMATED FUTURE . . .	$ 0.00	$ 340,000.00	$ 0.00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS:. . . . . $ 266,400.00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS . . . . . $ 2,809,193.00

B) COST TO THE INSURER OF THE PAYMENTS . . . . . $ 1,200,000.00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF . . . . . $ 3,181,600.00

D) DID YOU PURCHASE AN ANNUITY? X (01) Yes ___ (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: Roxanne Mullis: $2,000 per month starting 5/1/95 increasing to $2,679.19 per month on 12/1/05 plus lump sum of $164,204 on 4/5/07. Jason Mullis: $25,000 per year 11/20/20-23; lump sum of $50,000 12/20/07; lump sum $427,070 12/20/12. Ryan Mullis: $25,000 per year 11/6/04-07; lump sum $50,000 11/6/11; lump sum $670,913 11/6/16

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check One)

X (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.	0%	Health	D.	0%	Automobile
B.	0%	Disability	E.	0%	Medicare, Medicaid & Social Security
C.	0%	Worker's Compensation	F.	0 %	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