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

9401842
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 92-17669-01-035

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: MACMURRAY, ROBERT JAMES
(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|1|4|5|8|0|

3c. INSURED'S NAME: ROBERT J MACMURRAY, M.D.

STREET ADDRESS: SUITE 101, 631 PALM SPRINGS DRIVE

CITY: ALTAMONTE SPRINGS STATE: | F | L | ZIP: | 3 | 2 | 7 | 0 | 1 | COUNTY CODE: | 1 | 7 | (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	1002431	$ 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? ___ (01) Yes _X_ (02) No (If yes, enter the Country in which primary medical education was received: ___

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 | 4 | 2 | 0 | (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classisification Codes.)

8. BOARD CERTIFICATION: (Check One)

_X_ (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)
___ (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
_X_ (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: N/A INSTITUTION CODE: 9 9 9 9 9 9 (See Table D)

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

___ (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
___ (11) Other: _____

13. DATE OF OCCURRENCE: 30/01/90

DATE REPORTED TO INSURER: 07/20/92

14. INJURED PERSON'S AGE: 67 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: _

nd

STREET ADDRESS: _

CITY: \

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
Lung cancer.

(LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
None.

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Death.

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:
Member found lesion on patient's lung during chest X-ray. Patient was referred to a pulmonologist but did not follow-up. Case was tried and a jury found our Member not guilty.

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:
Death.

19.

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: 1/06/93

21.1 CIRCUIT COURT CASE NUMBER: CI 92-9613

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | 0 | 7 | (SEE TABLE B)

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)	Schultz, Robert W., M.D.	80280	93-17669-02-038
2)	Ball, Jr., James B., M.D.	80280	93-17669-03-038
3)	Bidwell, Clifford D., M.D.	80280	93-17669-04-038
4)	Vangrov, Mark S., M.D.	80280	93-17669-05-038
5)	Froom, Jr., Fenton E., M.D.	80280	93-17669-06-038

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

24. DATE OF FINAL CLAIM DISPOSITION: 9/27/94

25. FINAL METHOD OF CLAIM DISPOSITION:
___ (01) Settled by parties.
X (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.
X (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.

CLOSED CLAIM REPORTING FORM
(CONTINUED)

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE II
6)	Rippe, David J., M.D.	80280	93-17669-07-038
7)	Lester, Steven G., M.D.	80425	93-17669-08-038
8)			
9)			
10)			
11)			
12)			

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

27. COURT: (Check One)

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

28. ARBITRATION: (Check one)

X (01) Claim not subject to arbitration.
___ (02) Claim subject to arbitration, but settlement reached in lieu of award.
___ (03) Award for plaintiff.
___ (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: . . . . . $ 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:. . . . . $ 152,054.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:. . . . . $ 63,493.00

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 . . .	$ 18,782.00	$ 0.00	$ 0.00
B) ESTIMATED FUTURE . . .	$ 0.00	$ 0.00	$ 0.00

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 X (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)

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