

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

83-4645-02-19
FILE# _____

PRIMARY CARRIER

Company Code 44050 (Florida Certificate of Authority Number)

Company Name PHYSICIANS PROTECTIVE TRUST FUND

(2523)

Policy Number 124100

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 84 FCC MM1 IAC 3

Insured Steven Honig, M.D.

Address 250 W. 63rd Street, Miami Beach, FL 33141

County Code 01

(1) Speciality Radiology Code 210

(2) Date of Incident (Month, Day, Year) 030783

(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) 042283

(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) 071583

A. Primary Indemnity \$ 5,042.~~00~~ C. Excess Indemnity \$ _____

B. Primary Defense \$ 11.~~00~~ 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.

Failure to diagnose hip fracture.