FILE NAME: The Budd Company (BUD)

DATE: 1972-1973

DOC#: BUD017

DOCUMENT DESCRIPTION: Workmen's Comp Claim of Kuykendall

Bernstein
12-5-72

Bof 27824

WCR 11-2-13

CASE # 7650
NAME Kirkendall, Homer
BADGE 427-7650
LOW 11-30-72 84
INJURY h-l-b-shoulder-hands-feet-
hearing

EXHIBIT
Bauer 19
2-8-13 WS
PENGAD 800-631-6989

CONFIDENTIAL-SUBECT TO PROTECTIVE ORDER_000306588

KUYKENDALL — Homer — H. — 9-6-40 DATE HIRED — 7650 CLOCK NUMBER

LAST NAME — FIRST — MIDDLE

DATE	DEPT.	CLOCK NO.	CODE	CLASSIFICATION	RATE	PART.	TERMINATION DATE	TERMINATION CODE
MAR 1 1954	320		P-14	COST OF LIVING REDUCTION 1¢ PER HR.	2.405	D		
JUN 1 1954				ANNUAL IMPROVEMENT 5¢ PER HR.	2.455	E		
JUN 7 1954				COST OF LIVING REDUCTION 1¢ PER HR.	2.405	D		
SEP 6 1954				COST OF LIVING INCREASE 1¢ HR.	2.455	D		
DEC 6 1954				COST OF LIVING REDUCTION 1¢ PER HR.	2.445	D		
JUN 1 1955				COST OF LIVING REDUCTION 1¢ PER HR.	2.495	E		
SEP 1 1955				ANNUAL IMPR. RETROACTIVE 6-1-55 5¢ per hr.	2.575	Sp.		
SEP 5 1956				SPEC. 8¢ TO SKILLED EMPL.	2.585	D		
MAR 5 1956				COST OF LIVING INCREASE 1¢ HR.	2.7	D		
APR 1 1956	427		P-14	COST OF LIVING REDUCTION 1¢ PER HR.	2.575			
JUN 1 1956				CHANGE DEPARTMENT NUMBER 61¢ hr.	2.640	E		
				COST OF LIVING INCREASE 1¢ HR.	2.650	D		
SEP 3 1956				COST OF LIVING INCREASE 4¢ HR.	2.690	D		
DEC 3 1956				COST OF LIVING INCREASE 2c PER HR.	2.710	D		
MAR 4 1957				COST OF LIVING INCREASE 1¢ HR.	2.720	D		
JUN 1 1957				(CONVERSION TO BASIC RATE) TO ELIMINATE COST OF LIVING	2.580			
JUN 1 1957				ANNUAL IMPROVEMENT FACTOR 6¢ PER HR.	2.645	E		
JUL 1 '58				ANNUAL IMPROVEMENT 5¢ PER HR.	2.695	E		
SEP 1 1958				TFR. 15¢ FROM COST OF LIVING	2.845	D		
SEP 1 1958				SPEC. 8¢ TO SKILLED	2.925	Sp.		
AUG 1 1959				ANNUAL IMPROVEMENT 7½¢ PER HR.	3.000	E		
SEP 1 1959				ANNUAL IMPROVEMENT 7.5 PER HR.	3.075	E		

A—APPRENTICE OR AUTOMATIC
B—RECLASSIFICATION
C—MERIT INCREASE

ADD CURRENT COST OF LIVING

D—COST OF LIVING
E—ANNUAL IMPROVEMENT

F 7137 7M 3-53

BUDD WHEEL CO.
EDW. G. BUDD MFG. CO. — Kuykendall, Homer H. — 7650

H-HIRED T-TRANSFERRED R-REHIRE CR-CHANGE OF RATE

DATE	DEPT.	CLOCK NO.	RATE	OCCUPATION	TERMINATION DATE	TERMINATION L. D. W.	STATUS ABILITY	STATUS CONDUCT
7-19-43	50	055	1.565	Pipefitter				
T5-15-47	306	223	1.715	Pipefitter	CHANGE DEPARTMENT NUMBER			
9-7-53	320	223	1.715	Pipefitter	CHANGE DEPARTMENT NUMBER			
4-2-56	427	7650	1.715	Pipefitter				

CONFIDENTIAL-SUBECT TO PROTECTIVE ORDER

FORM 104
REV. 1-71

Three (3) O.D. Claims Filed

STATE OF MICHIGAN
DEPARTMENT OF LABOR

BUREAU OF WORKMEN'S COMPENSATION

PETITION FOR HEARING

THIS FORM TO BE USED FOR
1. All compensation claims. ☐
2. Petition for change of medical. ☐
3. Petitions to fix fees. ☐
4. Rehabilitation. ☐

EMPLOYEE KUYKENDALL, Homer H. Sanders Drive, LaVergne, Tennessee
(Last, First, M.I, Street Address, City)

SOCIAL SECURITY # 408-03-0595 DATE OF BIRTH June 14, 1914

EMPLOYER The Budd Company, c/o Workmen's Comp. Dept. 12141 Charlevoix Avenue, Detroit, Michigan 48215
(Street Address, City)

INSURANCE COMPANY (not agent) (Do not fill in unless known)

RECEIVED
DEC 6 1972
EDWARD D. WOLF
WORKMEN'S COMPENSATION

The applicant respectfully shows:

1. That this claim relates to a personal injury which occurred on or about (1) O.D. December 1, 1972 (2) O.D. December 1, 1972 (3) O.D. December 1, 1972

at (Plant, Store, Accident)

OR to a disablement from occupational disease which occurred on or about

2. That the injury or disablement occurred at Detroit (City) Wayne (County) Michigan (State) and in the following manner The Plaintiff was exposed to various deleterious media and was engaged in hard, arduous, strenuous, difficult manual labor which required fast heavy lifting, bending, twisting, turning and under much pressure. The Plaintiff was also exposed to constant noise.

December 1, 1972 (Last day worked) $225.00 (Daily Wage at time of injury or disablement) (Weekly earnings)

3. Nature of disability (1) Pneumoconiosis; Asbestosis; Heart Condition and sequelae; (2) Generalized Arthritis of back and spine, shoulders, hands and feet; (3) Bilateral Diminution of Hearing related conditions. (Describe injury, disease, state specific disease)

Date of recovery Not Date of return to work Not

4. If death resulted, give date of death Relationship of applicant to deceased

5. Names of persons dependent upon injured employee on date of injury Wife, Estelle Kuykendall

6. Has compensation been paid or is compensation being paid for this injury? Yes.... No.....

7. If adjustment of attorney or medical fees or funeral expense is sought, please state which and amount Medical

8. The employer or insurance carrier is authorized to obtain Social Security records. Yes.... No. X..

Wherefore applicant requests that he be granted such relief as he is entitled to under the Workmen's Compensation Law of Michigan and that the Bureau set this matter for hearing so that the parties hereto may have a determination of their rights under the Workmen's Compensation Law.

Dated at Detroit, Michigan, this 5th day of December 19 7

Name and address of Plaintiff's Attorney (if any)

BERNSTEIN & BERNSTEIN
Attorneys for Plaintiff
1632-42 First National Building
Detroit, Michigan 48226
Telephone: 963-2340-1-2

Signed Homer H. Kuykendall (Applicant must sign here)

Homer H. Kuykendall,
Sanders Drive, LaVergne, Tennessee.
Address

NOTE:—Either party to a dispute regarding compensation matters may apply to the Bureau for an adjustment of its claim. Three copies of this application must be mailed to the Bureau of Workmen's Compensation, Lansing, Michigan 48926. The applicant should keep one copy.

Rev. 7-72

DEPARTMENT OF LABOR
BUREAU OF WORKMEN'S COMPENSATION
LANSING, MICHIGAN

☐ Supplemental 101
☐ If Corrected 101
Explain

NOTICE OF COMMENCEMENT OF COMPENSATION PAYMENTS

INS. CO. FILE#

1. Name of employee Kuykendall (Last) Homer (First) H. (Middle) SSN 408-03-8593
2. Address 987 Sanders Drive City LaVergne, Tennessee
3. Date of Personal Injury 11-30-72 (LDW); 12-1-72 (LDW) 4. Last day worked 5. Date Disability Commenced
6. Nature of Personal Injury Heart & lung disease, pneumoconiosis, asbestosis, arthritis of back, spine, shoulders, hands & feet, upper & lower extremities, back, herniae, bilateral hearing loss & sequelae
7. Straight Time Earnings: Hourly rate ____ Total $ ____
   Overtime Earnings: Hourly rate ____ Hours per week ____ Total $ ____
   If board, room furnished give value ____ Total $ ____
   Combined weekly earnings $ ____
   If on piece work or Commission, explain fully ____
8. Number of dependents ____
9. Compensation rate ____ If partial, explain ____
10. Date first payment due ____ Date first payment actually made ____
11. Name of Employer The Budd Company Address 2155 W. Big Beaver, Troy 48084
12. Name of Insurance Company Self-Insured Address ____
13. Date of this report November 30, 1973 Signature of designated agent of insurer or self-insured employer.
    THE BUDD COMPANY
    By: Steve N. Yardley

Form 102

NOTICE OF STOPPING OF COMPENSATION PAYMENTS

☐ Initial 102
☐ Supplemental 102
☐ If Corrected 102
Explain

14. Payments have been stopped for following reason (check one)
   (a) ☐ Returned on ____ (Date) to work of equal skill ☐ or at same wage ☐ as when injured
   (b) ☐ Recovered from disability
   (c) ☒ Other, specify Redemption
15. Basis of compensation payments made.

From (Dates are inclusive)	To	Weeks	Days	Kind	Weekly Wages Paid if Compensation Rate IS Partial	Weekly Rate of Compensation	Total Amount
				Total			
				Partial	REDEMPTION		$1,500.00
				Specific loss			
				Death			

16. Date payment made for award with interest ____ Burial allowance ____
    Total $1,500.00
17. Date of this report November 30, 1973 Signature of designated agent of insurer or self-insured employer.
    THE BUDD COMPANY
    By: Steve N. Yardley

Form 101-A
Rev. 7-72

EMPLOYER OR INSURER: Answer the following but do not detach.

Our records indicate the average weekly wage to be $____ per week, the number of dependents to be ____ (not including yourself). You will receive (or have already received) $____ per week from your employer or his insurance company. If any of this information is incorrect, please write to the Department of Labor, Bureau of Workmen's Compensation, 300 E. Michigan Ave., Lansing, Michigan 48926.

Name and Address of Injured, Below

Homer H. Kuykendall
987 Sanders Drive
LaVergne, Tennessee

Employer The Budd Company
Insurance Carrier Self-Insured
Date of Injury 11-30-72 (LDW); 12-1-72 (LDW)