FILE NAME: Insulators Workers' Comp Claims (IWC)

DATE: 1966

DOC#: IWC057

DOCUMENT DESCRIPTION: Claimant - Taylor, Lawrence J., Sr. [From J-M Archive]

File Name	Contract Unit Claim File: Lawrence J. Taylor Sr.
Scanned ?	yes
Source	JMA: NS-JM
Start Year	1966
Stop Year	1966
Contents	claim
Notes	

WORKMEN'S COMPENSATION DEPARTMENT
LANSING, MICHIGAN

EMPLOYER'S BASIC REPORT OF COMPENSABLE INJURY

(COPY SHALL BE GIVEN IMMEDIATELY TO INJURED EMPLOYEE AND INSURANCE CARRIER)

Employers must report immediately to the Department on Form 109 all injuries, including diseases, which arise out of and in the course of the employment and cause: 1. An aggregate of seven ( ) or more days of disability not including Sundays or the day of injury. 2. Death. 3. Specific Losses. In case of **DEATH** also file immediately an additional report on Form 106.
See Additional Instructions on Reverse Side. The Travelers Insurance Company

EMPLOYER Johns-Manville Sales Corporation (Assumed name, if any) — M. E. & C. Number 14

832 Fisher Bldg. (Address—Street and Number) Detroit (City) 2, Michigan (State)

TYPE OF BUSINESS Industrial Insulation

INSURANCE CARRIER THE TRAVELERS INSURANCE COMPANY 719 Griswold Street, Detroit 26, Mich.

INJURED EMPLOYEE Laurence J. Taylor Sr. (First name) (Middle initial) (Last name) Soc. Sec. No. 374-01-6553

Address 16854 Beaverland (Street and number) Detroit, (City) Michigan (State) Marital status M

Age 60 If under 18, Occupational Approval No. ____ Wkmg. Permit No. ____ Sex M

Number of injured employee's children under age 16, living with injured. ____

If injured is a married man, is wife living with him? Yes

Number of other family members or relatives at least 50% supported by injured. ____

DATE OF INJURY 6-10-66 Last day worked 6-13-66

Describe injury or disease Collapsed Lung.

If specific loss, give date of loss 6-13-66

How did injury or disease happen? after moving a load of material this man had to sit down because he was all out of wind.

Where? City Romulus State Michigan

Foreman Laurence Taylor Witnesses ____

Physician ____ Hospital New Grace Hospital

Address ____ (Street and number) (City) (State)

Occupation of injured employee ____

Straight Time Earnings: Hourly rate ____ Hours per week ____ 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 ____

Estimated length of disability ____

HAS A COPY OF THIS REPORT BEEN GIVEN TO EMPLOYEE? Yes No

L Durant

Signature (in ink) **EMPLOYER** or Representative (Not Insurance Carrier)

Date of Report ____

(R-0613) REV. 7-66 Printed in U.S.A.

(LEAVE BLANK)

DO NOT WRITE IN THIS COLUMN

CASE NO

EMPLOYER NO

INSURANCE

PLACE OF INJURY

DATE OF INJURY

NATURE

LOCATION

DISABILITY

AGE

OCCUPATION

CONJUG COND & SEX

DEPENDENTS

WEEKLY WAGE

AGENCY

INJURY TYPE

CODED BY

SUPERVISOR'S INVESTIGATION
REPORT

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and name them and to state the remedy for them in this report.

COMPANY: Johns-Manville Sales Corporation

BRANCH OR SUBSIDIARY: [illegible]

LOCATION OF ACCIDENT (The name or number of building, store, dept., floor, etc.): Metro Airport [illegible]ulus, Michigan

DATE AND HOUR OF ACCIDENT: [illegible]

NAME OF INJURED PERSON: Lawrence J. Taylor Sr.

INJURED'S DEPT. OR DIVISION: Ind.

INJURED'S JOB OR POSITION: Foreman

DESCRIBE THE INJURY: Collapsed Lung

DESCRIBE THE ACCIDENT (State what the injured was doing and the circumstances leading to the accident)

After moving a load of insulating material this man was struggling to get his breath, about that time I happened on the job and saw him, I asked what was wrong and he told me he was having trouble getting his breath, this was on Friday he worked the following Monday still having a little trouble but on Tuesday morning he came in and had to go back home. He went to the doctor and the doctor put him in the hospital.

UNSAFE CONDITION (Describe as oily floor, poor light, lack of guards on belts and gears, broken steps, etc.)

None

UNSAFE ACT - UNSAFE WORK PROCEDURE (Described as removed guard, adjusted moving machine, or a specific item of unsafe procedure, lack of planned safety, etc.)

None

REMEDY (As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident?)

None

SUPERVISOR: L. Berardi [signature]

REVIEWED AND APPROVED BY: [signature]

DATE REPORT PREPARED: 6-20-66

(Use reverse side for sketch and additional detail.)

C-6050 REV. 4-60 [illegible]

FILING DUE 8-18

30 DAY DUE 10-18

LIABILITY

AUG 8-18

ABA OFFICE	DATE NOTICE RECEIVED	FILE NO.
Detroit	7-18-66	1664531

Johns-Manville Corp, Johns-Manville Sales Corp.

22 East 40th St. New York, N. Y.

CODE: 14

LOCATION OF RISK: 522 Fisher Bldg. Detroit, Mich.

DATE	POLICY NUMBER	POLICY PERIOD	POL. YEAR	PRODUCER'S NAME AND CODE
6-30-66	2679006	7-1-65/66	66	Marsh & McLellan, Inc.

STATE: Mich.

ABA STATE (Claim Dept. Use Only)

CLASSIFICATION OF OPERATIONS (Enter abbreviated description of governing classification and all code numbers.)

Insulation work, etc., 5479, 5551, 5184, 8018, 8810, 8742

ENDORSEMENTS (Give number and brief description of such endorsements as affect coverage)

All States (2679006) Cov. B. $100,000

NAME OF EMPLOYEE	AGE	MAIL ADDRESS
Lawrence J. Taylor, Sr.	60	16654 Beaverland Detroit, Mich.

OCCUPATION: Foreman

TYPE OF MACHINE, IF ANY

LOCATION OF ACCIDENT (Room, Dept., or Yard) AND (No., Street, and City)

Rawlins Michigan

CAUSE OF ACCIDENT OR DISABILITY (As reported)

Ins., became winded after moving load of material.

NATURE OF INJURY OR DISEASE (As reported)

collapsed lung

REG. APPD BY: JA:bsa 7-25-66

DELAYED NOTICE

IF OCC. DISEASE, SHOW TYPE OF COV. ☐ COV. A ☐ COV. B

ITEMS	OPEN CASE EST. INCURRED LOSS	AMOUNT PAID FINAL	REOPENED FINAL
Fat. & I.M.C.			
Vol. Comp.			
Temp. Total	45x		
Temp. Partial			
Perm. Total			
Perm. Partial			
Disfigurement			
Total			
Fun'l Exp.			
Medical	2000		
Expense	300		

ENTER BASIS OF PERM. PARTIAL PAID, IF ANY. If schedule or schedule is, show percentage and number, otherwise indicate method of computing P.P. paid.)

AMOUNT PAID-FINAL-APPROVAL

REOPENED-FINAL-APPROVAL

Did investigation disclose ... (Yes or No)

Is right of subrogation involved (Yes or No)

Reopened case Previously paid: CLAIM | MEDICAL | EXPENSE

CITY	COV.	CLASS	VC-IL	

NO. WK | NO. C. | NO. MED

For Home Office use only

ABA OFFICE	ACC. MO	ACC. YR	POL YR	OFFICE	STATE	RETRO	LINE	COV.	WKLY. WAGE	CODER	CLASS	S Z	COV	TYPE LOSS

NOTICE REGISTER | CHANGE IN REG | EXAMINER | UND SERVICE | CAS. ACT'L CHANGES

NOTICE REG

EXPIR.

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- unnumbered images