STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

____, WCA No.:____________________

Worker,

v.

____, and

____,

Employer/Insurer.

PETITION FOR LUMP SUM PAYMENT

A. GENERAL INFORMATION: This petition seeks approval of the following lump sum payment:

1. ___ Lump sum payment after return to work for 6 months, earning at least 80% of the pre-injury wage pursuant to Section 52-5-12(B). Copies of wage statements should be attached.
2. ___ Partial lump sum payment to pay debts accumulated during the course of the disability pursuant to Section 52-5-12(C). Copies of records documenting the debts accumulated should be attached.
3. ___ Lump sum settlement payment pursuant to Section 52-5-12(D). Must be filed jointly by the Worker and Employer/Insurer.

B. FACTUAL INFORMATION:

1. Type of injury: ___ Accidental Work Injury ___ Occupational Disease
2. Worker's Full Name: ____

   Mailing Address: ____

   City/State/Zip: ____

   Telephone: ____

   E-mail Address for service: ____

   Worker's highest level of school completed: ______________________________

   Worker's date of birth: __________________ Age: _____ Sex: __ M __ F

   Worker's Social Security No.: _____________
3. Full Name of Employer: ____

   Employer's Address: ____

   City/State/Zip: ____

   Telephone: ____

   E-mail Address for service: ____

4. Insurance Carrier: ____

   Address: ____

   City/State/Zip: ____

   Telephone: ____

   E-mail Address for service: ____

5. Date of Accident: ____

   City and County of accident: ____

   How did the accident occur: ____

   Nature of the injury: ____

   Part(s) of the body injured: ____

   First date Worker was unable to perform job duties: ______________________________________

6. Worker's job at time of accident: ____

   Worker's average weekly wage: ____

   Weekly compensation rate: ____

7. Doctor's Name: ____

   Mailing Address: ____

   City/State/Zip: ____

   Telephone: ____

8. Doctor who set the maximum medical improvement: _____________________________________

   Date of maximum medical improvement: ____

   Impairment rating: ___________________ Date assessed: ______________________________________

   Has Worker been released to work by a Doctor? ___ Yes ___ No

      If yes, please indicate the date Worker was released to work: ____________________________

   Has Worker returned to work since the accident? ___ Yes ___ No

      If yes, please indicate the date Worker returned to work: _______________________________

9. Current Employer's Name: ____

   Mailing Address: ____

   City/State/Zip: ____

10. Is an interpreter needed for the hearings on this application? __ Yes __ No

      If yes, what language? ____
      (Employer will pay for cost of interpreter.)

11. Medicare Eligibility:

    Is Worker a current Medicare beneficiary? __ Yes __ No

    Has Worker applied for Social Security Disability benefits in the past 5 years? __ Yes ___ No

    Has Worker been diagnosed with End Stage Renal Disease? __ Yes __ No (*See* 42 U.S.C. § 426-1)

C. REQUEST FOR RELIEF:

Please state the terms of the lump sum payment sought or agreed upon, including (1) the amount of the lump sum payment requested, (2) the effect the payment will have on indemnity or medical benefits, including a description of any benefits remaining if the petition is granted, (3) whether any part of the claim will be closed, (4) the amount of costs and attorneys' fees requested, if any, and (5) the net amount to be paid to the Worker.

VERIFICATION OF THE WORKER

I, ____________________________, Worker, verify I have read this petition for lump sum payment.

In accordance with NMRA 1-011(B), I swear and affirm under penalty of perjury under the laws of the State of New Mexico that representations I make in this petition are true and correct, and that I understand the terms and conditions of the proposed lump sum payment. I understand that approval of this petition will affect my future entitlement to workers' compensation benefits.

____
Worker's signature Date

____
Signature of worker's attorney (if any)

____
Name

____
Address

____
City, State, Zip

____
Telephone

____
E-mail address for service

APPROVAL OF THE EMPLOYER/INSURER

(Only required for petitions seeking lump sum settlement payments under Section 52-5-12(D))

I, _____________________________, a representative of Employer/Insurer, state that I have read this petition for lump sum settlement payment, that I sign this Petition with full authority to do so. I also confirm that I understand the terms and conditions of the lump sum settlement payment and I understand that approval of this petition will affect my company's/client's obligation to pay under this lump sum settlement payment, and its future obligation to pay workers' compensation benefits.

____
Signature Date

____
Name

____
Address

____
City, State, Zip

____
Telephone

____
E-mail address for service

INSTRUCTIONS FOR USE: A request for setting and a summons for each responding party shall be filed with the petition if it is an initial pleading, unless the petition is a joint petition seeking a lump sum settlement payment.

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

____, WCA No.:____________________

Worker,

v.

____, and

____,

Employer/Insurer.

SUMMONS FOR PETITION FOR LUMP SUM PAYMENT

TO: _______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

GREETINGS:

You are directed to appear before the Workers' Compensation Administration and respond to this Petition. If you choose to file a written response to this Petition, you must file your response with the Workers' Compensation Administration Clerk of Court **within 10 days of receipt of this Petition.**

If you fail to appear and respond, the Workers' Compensation Administration may enter a judgment against you for the relief demanded in the Petition.

Worker or filing party's representative:

____

Address of Worker or filing party's representative:

____

____

WITNESSED AND SEALED BY THE CLERK OF THE WCA

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

____, WCA No.:____________________

Worker,

v.

____, and

____,

Employer/Insurer.

REQUEST FOR SETTING

1. WCA Judge assigned: ____
2. Are any other hearings currently set? ___ Yes ___ No
   If yes, please indicate the date of the hearing: ____
3. Specific matter to be heard: ____
4. Time required for hearing: ____
5. Is an interpreter required? ___ Yes ___ No
   (Employer/Insurer is responsible for making arrangements for the interpreter.)
6. Is telephonic appearance being requested? ___ Yes ___ No
   (Employer/Insurer is responsible for arranging the conference call.)

____
Signature

____
Print name

____
Address

____
City/State/Zip

____
Telephone

____
E-mail address for service