# 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.