

Volume

1

STATE OF NEW MEXICO

2005

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Workers' Compensation Administration

# EDI Proof of Coverage Manual

Updated 10/14

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## How To Contact Us

**S**tate of New Mexico, Workers' Compensation Administration (WCA).

**There are multiple** ways to contact the WCA for information.

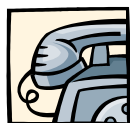
For questions regarding Proof of Coverage (POC), please contact WCA HelpDesk, at (505) 841-6817 or [wca.helpdesk@state.nm.us](mailto:wca.helpdesk@state.nm.us). A copy of the POC rules may be obtained on our website at [www.state.nm.us/wca/](http://www.state.nm.us/wca/)



P.O. Box 27198, Albuquerque, New Mexico 87125-7198



2410 Centre Avenue S.E., Albuquerque, New Mexico 87106

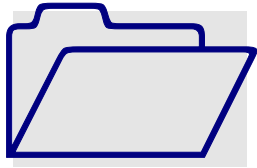


(505) 841-6000 or NM Toll Free 800-255-7965



[www.workerscomp.state.nm.us](http://www.workerscomp.state.nm.us)

## EDI Proof of Coverage Filing Requirements



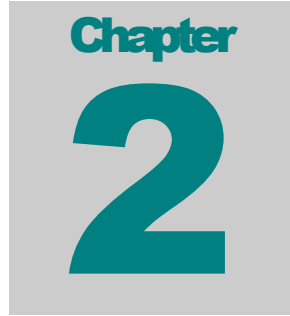
The Workers' Compensation Administration requires proof of coverage reporting in the IAIABC flat file format through approved vendors. Vendors must successfully pass testing with the WCA. The vendors must submit POC data in the IAIABC flat file format through a web-based secure FTP process. Vendors must provide carriers several options for submission of POC data. These options include:

- Hard Copy
- Mag Tape
- Web Page Form
- IAIABC Flat File

Each vendor must complete an EDI Proof of Coverage Sender/Vendor Information Form (P7) and an EDI Proof of Coverage Insurer Information Form (P8) for each carrier.

Prior to submitting POC to NM, each transaction must be tested by the vendor. Testing requirements are discussed in detail in this chapter.

Vendors must agree that all NM Proof of Coverage data is the property of the State of New Mexico Workers' Compensation Administration.



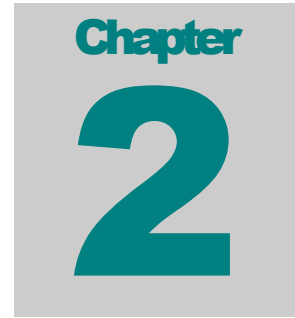
## **EDI Proof of Coverage Filing Requirements - Continued**

When submitting changes to policies, the WCA will update only the fields pertaining to the reported triplicate code. If changes are made to other fields in the policy, those other changes will not be updated.

For paired transactions (04 & 05) the '04' triplicate data must match data in database for mandatory (M) fields.

For '80' triplicate codes, the Number of Employers field is a mandatory (M) field. Since there will be no PC2 record submitted for an '80' code, this field must be entered as a zero '0'.

The Employer UI number is an optional field except for triplicates 04/05 32 78 & 04/05 32 95. This number must be reported on the '04' transaction as previously reported to the jurisdiction. The field must match what is in the database. Example: If the UI field was previously submitted with no information in the field (blank), it must be reported on the '04' transaction as a blank field



## Test Phase Requirements

**E**ach vendor sending EDI Proof of Coverage to the New Mexico Workers’

Compensation Administration must:

- Adhere to the WCA’s rules for EDI Proof of Coverage Filing
- Successfully complete a test phase with the WCA

Once a vendor is ready to begin testing with the WCA, the P7 form, EDI Proof of Coverage Sender/Vendor Information, and the P8 form, EDI Proof of Coverage Insurer Information, must be completed and submitted to the WCA. Submission of these forms by e-mail should be sent to [WCA.Helpdesk@state.nm.us](mailto:WCA.Helpdesk@state.nm.us). When faxing the above forms fax to the WCA, Attention: Helpdesk, Information Systems Bureau at (505) 841-6840. The vendor will be notified by e-mail when the information has been processed and the testing phase may begin. A revised form is required any time changes to the information occurs.

Following successful testing, an Insurer Profile form P8 must be submitted for each insurer the vendor is sending POC data for. A revised Insurer Profile is required any time changes to the profile occur.

Vendors must inform the WCA of any changes to their programs or systems prior to implementation of the changes. When a vendor implements changes, they are required to successfully complete another testing phase before data will be processed as production data.

For PC1 (Insured Record) data, real or created dummy data may be submitted.

The PC2 (Employer Record) data, if applicable, must be sent with PC1.

## Test Phase Requirements – Continued

**T**here is no strict timeframe that must be followed when performing the EDI test phase. The following items will be tested and reviewed:

1. Test data should be transmitted for a minimum of three (3) consecutive days.
2. Each vendor must submit every transaction set type during the test phase including binder, new policy, renewal, reinstatement, endorsements, cancellations, non-renewals and rewrites/reissues.
3. Header Format (See page 8 – POC Data Elements)
  - a. Header Length
  - b. Appropriate FEIN Number
  - c. Appropriate Data Formats
4. Trailer format (See Page 8 – POC Data Elements)
  - a. Trailer Length
5. PC1 Data File (See Page 9 – POC Data Elements)
  - a. Record Length
  - b. Date Format

## Test Phase Requirements – Continued

- c. Appropriate code entries (ex. two digit codes must be entered as 01 or 04)
  - d. Mandatory Fields
  - e. Appropriate values entered into mandatory fields
  - f. Number of employer records must equal number sent
6. PC2 Data File (See page 10 – POC Data Elements)
- a. Record Length
  - b. Date Format
  - c. Code Entries
  - d. Mandatory Fields
  - e. Appropriate values entered mandatory fields

## Notification

**T**he WCA will notify you via letter or e-mail when at least three consecutive days of test data (no less than a total of 60 records per day) has been transmitted to the WCA and has passed all test requirements. This notification will include the date to begin sending “production” instead of “test” data. If production data is received before formal approval is sent, the production data will not be processed.





## Records Formats and Mandatory Requirements

**I**ncluded in this section are:

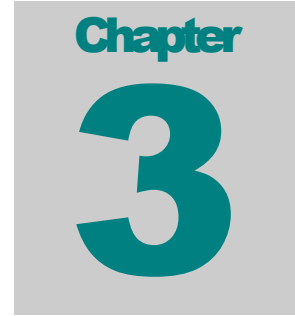
### NM WCA POC Informix Data Element Mapping

- Proof of Coverage – Insured Record
- Proof of Coverage – Employer Record
- Transaction Record

### NM WCA Flat File Layouts

- Proof of Coverage – Insured Record
- Proof of Coverage – Employer Record
- Proof of Coverage – Carrier Table
- Definitions:
  - M=Mandatory
  - O=Optional
  - C = Conditional

### WCA POC/IAIABC Data Element Mapping



## POC Data Elements

**M = Mandatory - data must be provided**

**O = Optional - data provided if available**

**C = Conditional - data must be provided under certain conditions**

Header Record Layout					
ELEM #	LOCATION	LENGTH	GROUPING	FIELD NAME	M/O/C
DN001	1 - 3	3	Transaction	Transaction Set ID	M
DN098	4 - 28	25	Sender	Sender ID	
		9		Sender Fein	M
		7		Filler	
		9		Sender Postal Code	M
DN099	29 - 53	25	Receiver	Receiver ID	
		9		Receiver Fein	M
		7		Filler	
		9		Receiver Postal Code	M
DN100	54 - 61	8	Transmission	Date Transmission Sent	M
DN101	62 - 67	6		Time Transmission Sent	M
DN102	68 - 75	8		Original Transmission Date	M
DN103	76 - 81	6		Original Transmission Time	M
DN104	82 - 82	1		Test/Prod Indicator	M
DN105	83 - 87	5		Interchange Version ID	
		3		Transmission Type Code	M
		2		Version Number	M

Trailer Record Layout					
ELEM #	LOCATION	LENGTH	GROUPING	FIELD NAME	M/O/C
DN001	1 - 3	3	Transaction	Transaction Set ID	M
DN106	4 - 12	9		Detail Record Count	M



## POC Data Elements

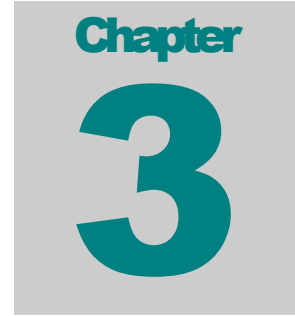
Insured Record Layout					
ELEM #	LOCATION	LENGTH	GROUPING	FIELD NAME	M/O/C
DN001	1 – 3	3	Transaction	Transaction Set ID	M
DN107	4 – 12	9		Record Sequence Number	M
DN300	13 – 14	2		Transaction Set Purpose Code	M
DN302	15 – 22	8		Jurisdiction Designee Receive Date	M
DN002	23 – 24	2		Transaction Set Type Code	M
DN303	25 – 26	2		Transaction Reason Code	M
DN304	27 – 34	8		Transaction Set Type Effective Date	M
DN006	35 – 43	9	Insurer	Insurer Fein	M
DN007	44 – 73	30		Insurer Name	O
DN305	74 – 103	30		Issuing Office Name	M
DN306	104 – 133	30		Issuing Office Address Line 1	M
DN307	134 – 163	30		Issuing Office Address Line 2	O
DN308	164 – 193	30		Issuing Office City	M
DN309	194 – 195	2		Issuing Office State	M
DN310	196 – 204	9		Issuing Office Postal Code	M
DN311	205 – 234	30	Agency	Issuing Agency Name	O
DN312	235 – 264	30		Issuing Agency City	O
DN313	265 – 266	2		Issuing Agency State	O
DN314	267 – 275	9	Insured	Insured Fein	M
DN017	276 – 365	90		Insured Name	M
DN315	366 – 395	30		Insured Address Line 1	M
DN316	396 – 425	30		Insured Address Line 2	O
DN317	426 – 455	30		Insured City	M
DN318	456 – 457	2		Insured State	M
DN319	458 – 466	9		Insured Postal Code	M
DN320	467 – 476	10		Insured Telephone Number	O
DN321	477 – 477	1		Business Market	M
DN322	478 – 478	1		Wrap-Up Indicator	M
DN323	479 – 480	2		Insured Legal Status	M
DN028	481 – 498	18	Policy	Policy Number	M
DN333	499 – 499	1		Employee Leasing Policy Identification	M
DN332	500-500	1		Minimum Premium Indicator	M
	501 – 510	10		Filler	
DN029	511 – 518	8		Policy Effective Date	M
DN030	519 – 526	8		Policy Expiration Date	M
DN324	527 – 544	18		Prior Policy Number	O
	545 – 556	12		Filler	
DN325	557 – 564	8		Assignment Date	C
DN004	565 – 566	2	Jurisdiction	Jurisdiction	M
DN326	567 – 570	4		Governing Class	M
DN327	571 – 581	11		Total Payroll	M
DN328	582 – 585	4	Employer Cnt	Number of Employers	M



## POC Data Elements

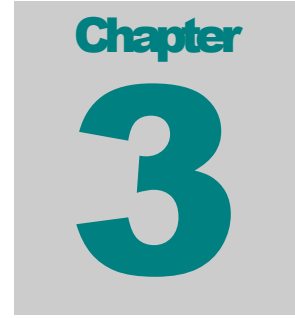
Employer Record Layout					
ELEM #	LOCATION	LENGTH	GROUPING	FIELD NAME	STATE
DN001	1 - 3	3	Employer Segment	Transaction Set ID	M
DN107	4 - 12	9		Record Sequence Number	M
DN016	13 - 21	9		Employer Fein	M
DN329	22 - 36	15		Employer UI Code	O
DN018	37 - 96	60		Employer Name	M
DN019	97 - 126	30		Employer Address Line 1	M
DN020	127 - 156	30		Employer Address Line 2	O
DN021	156 - 171	15		Employer City	M
DN022	172 - 173	2		Employer State	M
DN023	174 - 182	9		Employer Postal Code	M
DN025	183 - 188	6		Industry Code	M
DN330	189 - 194	6		Number of Employees	M
DN331	195 - 202	8		Employer Notification Date	O

POC Acknowledgment Record Layout					
ELEM #	LOCATION	LENGTH	GROUPING	FIELD NAME	STATE
DN001	1 - 3	3	Detail Acknowledgment	Transaction Set ID	M
DN107	4 - 12	9		Record Sequence Number	M
DN108	13 - 20	8		Date Processed	M
DN109	21 - 26	6		Time Processed	M
DN006	27 - 35	9		Filler	
DN014	36 - 44	9		Filler	
DN008	45 - 53	9		Filler	
DN110	54 - 56	3		Acknowledgment Transaction Set ID	M
DN111	57 - 58	2		Application Acknowledgment Code	M
DN026	59 - 83	25		Filler	
DN015	84 - 108	25		Filler	
DN005	109 - 133	25		Filler	
DN002	134 - 135	2		Filler	
DN003	136 - 143	8		Filler	
DN112	144 - 146	3		Request Code (Purpose)	M
DN113	147 - 206	60		Free form text	
DN114	207 - 208	2		Number of errors	M
				Variable Segment Occurs Number of Error Times	
DN115	209 - 212	4	Error Code	Element Number	M
DN116	213 - 215	3		Element Error Number	M
DN117	216 - 217	2		Filler	



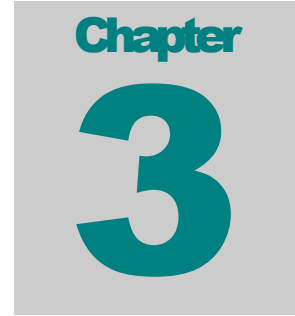
## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																
		00 05 01	00 05 80	00 05 86	00 10 01	00 10 80	00 10 86	00 20 01	00 20 80	00 20 86	04 32 85	05 32 85	04 32 94	05 32 94	00 32 84	04 32 77	05 32 77	04 32 96
<b>Insured Record</b>	Transaction Set ID	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Record Sequence Number	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Purpose Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Jurisdiction Designee Received Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Reason Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Effective Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Name	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Issuing Office Address Line 1	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Issuing Office Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office City	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Issuing Office State	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Issuing Office Postal Code	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Issuing Agency Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured FEIN - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insured Name	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured Address Line 1	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured City	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured State	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured Postal Code	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured Telephone Number	O	O	O	O	O	O	O	O	O	O	O	O	O	M	O	O	O
	Business Market	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Wrap-Up Indicator	O	O	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Insured Legal Status	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Policy Number - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Minimum Premium Indicator	O	O	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O



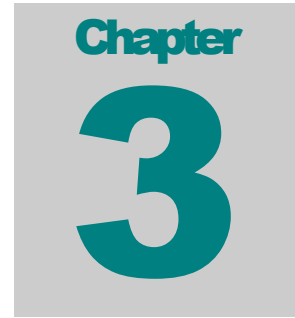
## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																
		00	00	00	00	00	00	00	00	00	04	05	04	05	00	04	05	04
	Purpose Code	00	00	00	00	00	00	00	00	00	04	05	04	05	00	04	05	04
	Type Code	05	05	05	10	10	10	20	20	20	32	32	32	32	32	32	32	32
	Reason Code	01	80	86	01	80	86	01	80	86	85	85	94	94	84	77	77	96
<b>Insured Record</b>	Employee Leasing Policy Identification	M	M	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Policy Effective Date - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Policy Expiration Date	M	M	O	M	M	O	M	M	O	O	O	O	O	O	O	O	O
	Prior Policy Number	O	O	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O
	Assignment Date	C	C	O	C	C	O	C	C	O	O	O	O	O	C	O	O	O
	Jurisdiction	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Governing Class	O	O	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Total Payroll	O	O	O	M	M	O	M	M	O	O	O	O	O	M	O	O	O
	Number of Employers	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
<b>Employer Record</b>	Transaction Set ID	M		M	M		M	M		M	M	M	M	M		M	M	M
	Record Sequence Number	M		M	M		M	M		M	M	M	M	M		M	M	M
	Employer FEIN - Key	M		M	M		M	M		M	M	M	M	M		M	M	M
	Employer UI Code	O		O	O		O	O		O	O	O	O	O		O	O	O
	Employer Name - Key	M		M	M		M	M		M	M	M	M	M		M	M	M
	Employer Address Line 1 - Key	M		O	M		O	M		O	M	M	O	O		M	M	O
	Employer Address Line 2	O		O	O		O	O		O	O	O	O	O		O	O	O
	Employer City	M		O	M		O	M		O	M	M	O	O		M	M	O
	Employer State	M		O	M		O	M		O	M	M	O	O		M	M	O
	Employer Postal Code	M		O	M		O	M		O	M	M	O	O		M	M	O
	SIC Code	M		M	M		M	M		M	M	M	O	M		O	O	O
	Number of Employees	O		O	M		M	M		M	M	M	O	M		O	O	O
	Employer Notification Date	O		O	O		O	O		O	O	O	O	O		O	O	O



## Mandatory Fields

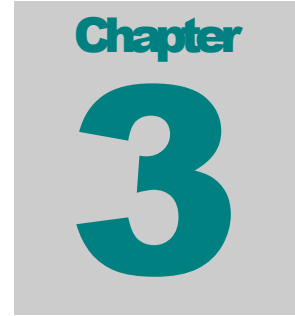
Key Fields Change Fields	Element Name	Triplicate Code																
		05	04	05	04	05	04	05	04	05	04	05	04	05	04	05	04	05
	Purpose Code	32	32	32	32	32	32	32	32	31	33	32	32	32	32	32	32	32
	Type Code	96	78	78	95	95	79	79	76	76	76	76	81	81	82	82	83	83
	Reason Code																	
<b>Insured Record</b>	Transaction Set ID	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Record Sequence Number	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Purpose Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Jurisdiction Designee Received Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Reason Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Effective Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Address Line 1	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M
	Issuing Office Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M
	Issuing Office State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M
	Issuing Office Postal Code	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M
	Issuing Agency Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured FEIN - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insured Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured Address Line 1	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured Postal Code	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured Telephone Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Business Market	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Wrap-Up Indicator	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured Legal Status	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Policy Number - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Minimum Premium Indicator	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O



## Mandatory Fields

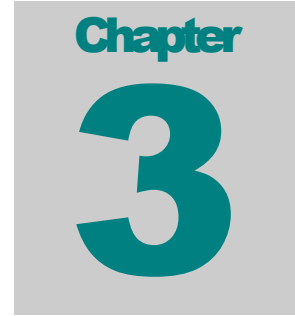
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	Type Code	96	78	78	95	95	79	79	76	76	76	76	76	81	81	82	82	83	
	Reason Code																		
Insured Record	Employee Leasing Policy Identification	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Policy Effective Date - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Policy Expiration Date	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O	
	Prior Policy Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Assignment Date	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Jurisdiction	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Governing Class	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Total Payroll	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Number of Employers	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
Employer Record	Transaction Set ID	M	M	M	M	M													
	Record Sequence Number	M	M	M	M	M													
	Employer FEIN - Key	M	M	M	M	M													
	Employer UI Code	O	M	M	M	M													
	Employer Name - Key	M	M	M	M	M													
	Employer Address Line 1 - Key	O	M	M	O	O													
	Employer Address Line 2	O	O	O	O	O													
	Employer City	O	M	M	O	O													
	Employer State	O	M	M	O	O													
	Employer Postal Code	O	M	M	O	O													
	SIC Code	O	O	O	O	O													
Number of Employees	O	O	O	O	O														
Employer Notification Date	O	O	O	O	O														





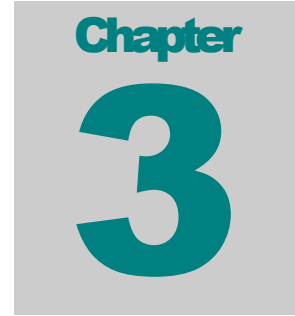
## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																
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<b>Insured Record</b>	Transaction Set ID	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Record Sequence Number	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Purpose Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Jurisdiction Designee Received Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Reason Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Transaction Set Type Effective Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insurer Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Name	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Address Line 1	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office City	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office State	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office Postal Code	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured FEIN - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insured Name	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured Address Line 1	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured City	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured State	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured Postal Code	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured Telephone Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Business Market	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Wrap-Up Indicator	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Insured Legal Status	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Policy Number - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Minimum Premium Indicator	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O



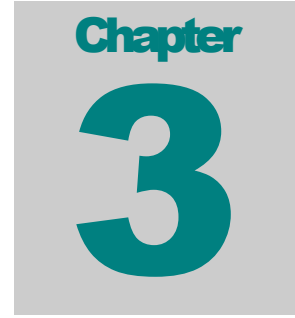
## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																
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<b>Insured Record</b>	Employee Leasing Policy Identification	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Policy Effective Date - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Policy Expiration Date	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Prior Policy Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Assignment Date	O	O	O	O	C	C	O	O	O	O	O	O	O	O	O	O	O
	Jurisdiction	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Governing Class	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Total Payroll	O	O	O	O	M	M	O	O	O	O	O	O	O	O	O	O	O
	Number of Employers	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
<b>Employer Record</b>	Transaction Set ID			M	M	M		M	M	M		M	M	M	M	M	M	
	Record Sequence Number			M	M	M		M	M	M		M	M	M	M	M	M	
	Employer FEIN - Key			M	M	M		M	M	M		M	M	M	M	M	M	
	Employer UI Code			O	O	O		O	O	O		O	O	O	O	O	O	
	Employer Name - Key			M	M	M		M	M	M		M	M	M	M	M	M	
	Employer Address Line 1 - Key			M	O	M		O	M	O		M	M	M	M	M	M	
	Employer Address Line 2			O	O	O		O	O	O		O	O	O	O	O	O	
	Employer City			M	O	M		O	M	O		O	O	O	O	O	O	
	Employer State			M	O	M		O	M	O		O	O	O	O	O	O	
	Employer Postal Code			M	O	M		O	M	O		O	O	O	O	O	O	
	SIC Code			M	M	M		M	M	O		O	O	O	O	O	O	
	Number of Employees			M	M	M		M	M	M		O	O	O	O	O	O	
	Employer Notification Date			O	O	O		O	O	O		M	M	M	M	M	M	



## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																	
		00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00		
	Purpose Code	42	42	42	42	42	42	42	60	60	60	60	60	60	70	50	50	50	
	Type Code	61	63	62	65	45	01	60	63	62	65	01	45	64	01	01	80	86	
	Reason Code																		
<b>Insured Record</b>	Transaction Set ID	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Record Sequence Number	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Transaction Set Purpose Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Jurisdiction Designee Received Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Transaction Set Type Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Transaction Reason Code - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Transaction Set Type Effective Date	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Insurer FEIN	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
	Insurer Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	Issuing Office Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Issuing Office Address Line 1	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Issuing Office Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Office City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Issuing Office State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Issuing Office Postal Code	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Issuing Agency Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Issuing Agency State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured FEIN - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Insured Name	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured Address Line 1	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured Address Line 2	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Insured City	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured State	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured Postal Code	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured Telephone Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
	Business Market	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Wrap-Up Indicator	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Insured Legal Status	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Policy Number - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Minimum Premium Indicator	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O



## Mandatory Fields

Key Fields Change Fields	Element Name	Triplicate Code																
		00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	
	Purpose Code	42	42	42	42	42	42	60	60	60	60	60	60	60	70	50	50	50
	Type Code	61	63	62	65	45	01	60	63	62	65	01	45	64	01	01	80	86
	Reason Code																	
<b>Insured Record</b>	Employee Leasing Policy Identification	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Policy Effective Date - Key	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Policy Expiration Date	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Prior Policy Number	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	M
	Assignment Date	O	O	O	O	O	O	O	O	O	O	O	O	O	O	C	C	O
	Jurisdiction	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Governing Class	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Total Payroll	O	O	O	O	O	O	O	O	O	O	O	O	O	O	M	M	O
	Number of Employers	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
<b>Employer Record</b>	Transaction Set ID													M		M		M
	Record Sequence Number													M		M		M
	Employer FEIN - Key													M		M		M
	Employer UI Code													O		O		O
	Employer Name - Key													M		M		M
	Employer Address Line 1 - Key													M		M		O
	Employer Address Line 2													O		O		O
	Employer City													O		M		O
	Employer State													O		M		O
	Employer Postal Code													O		M		O
	SIC Code													O		M		M
	Number of Employees													O		M		M
	Employer Notification Date													M		O		O



## Events Table

Refer to the IAIABC Implementation Guide for an explanation of the codes used for the following with respects to the Events Table:

- Transaction Set Purpose Code
- Transaction Type Code
- Transaction Reason Code

### Events Table – Proof of Coverage (POC)

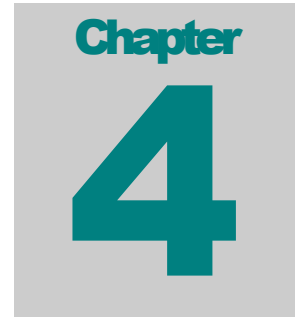
Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
Binder	30 Days from binder effective date	00	05	01
Binder – No physical location in jurisdiction	Insured has no physical address in area. 30 days from effective date.	00	05	80
Binder – No jurisdiction address for named employer	Insured does business in the jurisdiction and one or more employers do not have a physical address in the jurisdiction. 30 days from effective date.	00	05	86



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
New Policy	New policy for insurer. 30 days from effective date.	00	10	01
New Policy	Insured has no physical address in area. 30 days from effective date.	00	10	80
New Policy – No jurisdiction address for name employers	Insured does business in the jurisdiction and one or more employers do not have a physical address in the jurisdiction. 30 days from effective date.	00	10	86
Renew Policy	Continue policy for another term. 30 days from effective date.	00	20	01
Renew Policy	Insured has no physical address in area. 30 days from effective date.	00	20	80
Renew Policy – No jurisdiction address for named employers	Insured does business in the jurisdiction and one or more employers do not have a physical address in the jurisdiction. 30 days from the effective date.	00	20	86

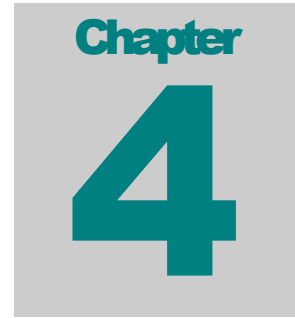


Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Changes</b>				
Change Name	Name change for employer	04 05	32 32	85 85
Change Address	Address change for employer	04 05	32 32	85 85
Change Industry Code	Industry code change for employer	04 05	32 32	85 85
Change # of Employees	Number of employees change for employer	04 05	32 32	85 85
Change Name Industry Code and/or # of Employees	Name, industry code and/or number of employees change for employer with no jurisdiction address	04 05	32 32	94 94
Change Legal Status	Legal status change of insurer	00	32	84
Change Insured Name	Name change of insured	00	32	84
Change Governing Class	Governing class change of insured	00	32	84
Change Total Payroll	Payroll change of insured	00	32	84
Change Insured Address	Address change of insured	00	32	84



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Changes</b>				
Change Telephone Number	Telephone number change of insured	00	32	84
Change Business Market	Business market change of insured	00	32	84
Change Wrap Up Indicator	Wrap up indicator change of insured	00	32	84
Change Assignment Date	Assignment date change of insured	00	32	84
Change Employee Leasing Policy Identification	Employee leasing policy identification change	00	32	84
Change Minimum Premium Policy Indicator	Minimum premium policy indicator change	00	32	84
Change Employer FEIN	Change of Employer FEIN	04 05	32 32	77 77
Change Employer FEIN	Change of Employer FEIN for employer with no jurisdiction address	04 05	32 32	96 96
Change Employer UI	Change of employer unemployment insurance number	04 05	32 32	78 78





Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Changes</b>				
Change Employer UI	Change of Employer UI for employer with no jurisdiction address	04 05	32 32	95 95
Change Policy Number	Change of policy number for insured	04 05	32 32	79 79
Change Insured FEIN	Change of insured FEIN	04 05	33 32	76 76
Add New Insured FEIN	Insured has obtained a new FEIN	04 05	32 31	76 76
Change Effective Date	Change in effective date	04 05	32 32	81 81
Change Expiration Date	Change in expiration date	04 05	32 32	82 82
Change Carrier FEIN	Change in carrier's FEIN	04 05	32 32	83 83
Include Corporate Officer/Partner Sole Proprietor	Policy amended to include these owners	00	32	67
Exclude Corporate Officer/Partner Sole Proprietor	Policy amended to exclude these owners	00	32	68



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Endorsements</b>				
Add Location(s)	Has added a new employer location to existing policy	00	31	54
Add New Employer with No Jurisdiction Address	Has added a new employer to an existing policy, however, employer does not have a physical address in the jurisdiction	00	31	87
Add Jurisdiction	Has added a new employer jurisdiction to existing policy that has not done business in jurisdiction	00	31	72
Add Jurisdiction with no state location	Has added the jurisdiction to an existing policy for employer without a physical location in jurisdiction.	00	31	80
Add Jurisdiction – Named Employer Has No Jurisdiction Address	Has added the jurisdiction to an existing policy and one or more employers do not have a physical address in the jurisdiction	00	31	86
Delete Location(s)	Delete employer location within an existing policy	00	33	56
Delete Employer with No Jurisdiction Address	Delete Employer operating in jurisdiction but with no jurisdiction address	00	33	87
Delete Jurisdiction	Delete jurisdiction location	00	33	73



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Cancelled by Insurer/Carrier</b>				
	Cancelled for non-payment	00	41	59
	Rewrite/Reissue	00	41	71
	Underwriting reason	00	41	64
	Failure to pay deductible	00	41	69
	Misrepresentation of information on application	00	41	70
	Revocation of voluntary market acceptance	00	41	66
<b>Cancelled by Insured</b>				
	Coverage placed elsewhere	00	42	60
	Duplicate coverage	00	42	61
	Change of ownership	00	42	62
	Business sold	00	42	63
	No employees, no exposure, no operations	00	42	65
	Out of business	00	42	45
	Reason Unknown	00	42	01



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Non-Renewal of Policy by Insured</b>				
	Coverage placed elsewhere	00	60	60
	Business sold	00	60	63
	Change of ownership	00	60	62
	No employees, no exposure, no operation	00	60	65
	Reason unknown	00	60	01
	Out of business	00	60	45
<b>Non-Renewal of Policy by Insurer</b>				
Underwriting Discretion	Carrier chose not to renew policy	00	60	64
Reinstate Policy	An insurer has cancelled policy but has now reconciled the dispute with the insured. Reinstate policy for original term	00	70	01
Rewrite/Reissue Policy	An insurer has cancelled policy but has now reconciled the dispute with the insured. Rewrite the policy for original term. Insurer uses new policy number	00	50	01



Transaction	Business Assumptions	Tran Set Pur Code	Tran Set Type Code	Tran Reason Code
<b>Non-Renewal of Policy by Insurer</b>				
Rewrite/Reissue Policy – Insured Has No Physical Location in Jurisdiction	An insurer has cancelled policy but has now reconciled the dispute with the insured. Rewrite the policy for the original term. Insurer uses new policy number. Insured does not have a physical location in the jurisdiction	00	50	80
Rewrite/Reissue Policy – Insured Has No Physical Location in Jurisdiction	An insurer has cancelled policy but has now reconciled the dispute with the insured. Rewrite the policy for the original term. Insurer uses new policy number. Insured does not have a physical location in the jurisdiction	00	50	86



## Business Requirements

1. Vendors will submit the data to the WCA using the IAIABC flat format.
2. Vendors will send data through a web based secure FTP file transfer.
3. Vendors must provide multiple options for insurers to submit POC data to the vendor.
  - Hard copy
  - Mag tape
  - Web page form
  - IAIABC Flat file
5. Vendors must pass a testing phase and be approved by the WCA
  - The vendor will send test data to the WCA to test the edit and acknowledgement process of the vendors software
  - After a vendor is approved by the WCA, they must notify the WCA of any changes in hardware or software and complete re-certification prior to using such changes.



## **Business Requirements – cont.**

6. Vendors must agree that all POC data are the property of the New Mexico Workers' Compensation Administration and the data cannot be used for any purposes other than those designated by the WCA.



## Paper Reporting Forms

**I**n this section you will find the following forms:

EDI Proof of Coverage Sender/Vendor Information (P7)

EDI Proof of Coverage Insurer Information (P8)





## Worker's Compensation Administration

EDI Proof of Coverage Sender/Vendor Information (P7 Form)

Add

Change

Delete

Test

This form is used to provide information on Senders/Vendors sending POC information via Electronic Data Interchange. Check the above boxes to indicate if this is an addition, a change, a deletion or a test. This form has two parts. The first part is used to provide the administration with information regarding the sender/vendor. The second part of this form is used to provide data regarding the companies a sender/vendor is sending data for. If a sender/vendor is also an insurer, the information should be listed in both parts of the form. The E8 form must be filed for each company listed in the second part of this form.

*Please type or print clearly:*

Sender/Vendor Name: \_\_\_\_\_ Sender/Vendor FEIN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact's Phone Number: \_\_\_\_\_ Contact's Email: \_\_\_\_\_

*Continued on next page*



**EDI Proof of Coverage Sender/Vendor Information P7 Form - Continued**

*Method of Transmittal: How the data files will be sent and acknowledgment files will be received*

Email Address \_\_\_\_\_

Licensed Vendor (Name): \_\_\_\_\_

Mail Box ID: \_\_\_\_\_ Acct. ID: \_\_\_\_\_

WEB       Other Software (Please list): \_\_\_\_\_

*Please list the names and FEINs of the companies you will be sending data for. If you are sending for your own company, please include that name and FEIN in this list as well. Remember to file an E8 for these companies as well:*

NAME	FEIN
Responsible Party Name:	Date:



## Workers' Compensation Administration

### EDI Proof of Coverage Insurer Information (P8 Form)

Add

Change

Delete

This form is used to provide information on Insurers submitting POC data via Electronic Data Interchange. Check the above boxes to indicate if this is an addition, a change or a deletion. Each entry on this form must correspond to an entry on an E7 Sender/Vendor form. Up to three insurers may be listed on this form. Attach additional E8 forms if necessary..

*Please type or print clearly:*

Sender/Vendor Name: \_\_\_\_\_ Sender/Vendor FEIN: \_\_\_\_\_

Contact  
Person: \_\_\_\_\_

Contact's Phone Number: \_\_\_\_\_ Contact's E-mail: \_\_\_\_\_

*Insurer Information:*

Insurer Name: \_\_\_\_\_ Insurer FEIN: \_\_\_\_\_

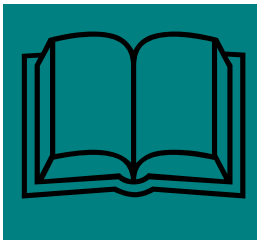
Mailing  
Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact  
Person: \_\_\_\_\_

Contact's Phone Number: \_\_\_\_\_ Contact's E-mail: \_\_\_\_\_

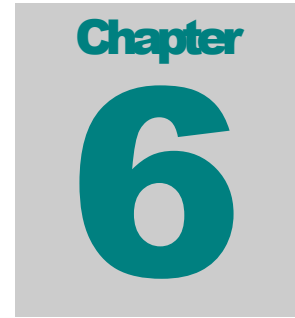
<b>Responsible Party Name:</b>	<b>Date:</b>
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## WCA Rules for Proof of Coverage

**F**ollowing are the New Mexico Workers' Compensation Administration's rules regarding

Proof of Coverage. Should you have any questions or concerns regarding the rules, contact WCA HelpDesk at (505)841-6817 or [wca.helpdesk@state.nm.us](mailto:wca.helpdesk@state.nm.us). A copy of the rules may be obtained on the WCA website at [www.workerscomp.state.nm.us](http://www.workerscomp.state.nm.us)



**TITLE 11 LABOR AND WORKERS COMPENSATION**  
**CHAPTER 4 WORKERS' COMPENSATION**  
**PART 11 PROOF OF COVERAGE**

**11.4.11.1 ISSUING AGENCY:** Workers' Compensation Administration  
 [8/1/96; 11.4.11.1 NMAC - Rn, 11 NMAC 4.11.1, 8/1/03]

**11.4.11.2 SCOPE:** This rule applies to all insurers issuing workers' compensation coverage in the state of New Mexico, all self-insured groups issuing workers' compensation coverage in the state of New Mexico and all vendors submitting proof of coverage (POC) information either on behalf of themselves or for others who are required to report such coverage.  
 [8/1/96; 11.4.11.2 NMAC – Rn & A, 11 NMAC 4.11.2, 8/1/03]

**11.4.11.3 STATUTORY AUTHORITY:** Sections 52-1-4.1 and 52-5-4 NMSA 1978 (Repl. Pamp. 1991) and department of insurance regulation 17, rule 2.  
 [8/1/96; 11.4.11.3 NMAC - Rn, 11 NMAC 4.11.3, 8/1/03]

**11.4.11.4 DURATION:** Permanent  
 [8/1/96; 11.4.11.4 NMAC - Rn, 11 NMAC 4.11.4, 8/1/03]

**11.4.11.5 EFFECTIVE DATE:** August 1, 1996  
 [8/1/96; 11.4.11.5 NMAC - Rn, 11 NMAC 4.11.5, 8/1/03]

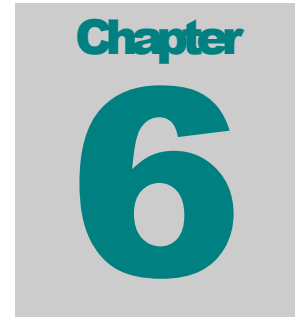
**11.4.11.6 OBJECTIVE:** The purpose of this rule is to establish requirements governing workers' compensation insurance proof of coverage.  
 [8/1/96; 11.4.11.6 NMAC – Rn & A, 11 NMAC 4.11.6, 8/1/03]

**11.4.11.7 DEFINITIONS:**

A. "Certified vendor" (also referred to as a "vendor") means a company or business which electronically transmits proof of coverage insurance information to the workers' compensation administration either for itself or for others and certified by the WCA as being qualified to submit POC data using the IAIABC format. The terms "certified vendor" and "vendor" are used interchangeably within this rule and carry the same meaning. A vendor's identity is not considered a record of the workers' compensation administration and is therefore not protected by the confidentiality provision.

B. "Filed" means that the policy information required under these rules has successfully passed all edits and has been accepted, date and time stamped and uploaded into the workers' compensation administration's database.

C. "IAIABC" means the International Association of Industrial Accident Boards and Commissions.



**TITLE 11 LABOR AND WORKERS COMPENSATION**  
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D. "Insurer" means any insurance carrier or self-insured group or other entity that issues a workers' compensation insurance policy or provides workers' compensation coverage for itself or subsidiaries by any other means.

E. "POC flat file" or "POC flat file format" means the IAIABC defined standard in which proof of coverage (POC) data is electronically submitted to the WCA.

F. "WCA certified" or "WCA certification" means a vendor has received approval from the WCA to submit POC data electronically. WCA certification is required prior to submitting POC data.

[8/1/96; 11.4.11.7 NMAC – Rn & A, 11 NMAC 4.11.7, 8/1/03]

**11.4.11.8 PROOF OF COVERAGE:**

A. Filing requirements:

(1) Every insurer shall file proof of coverage with the workers' compensation administration within thirty (30) days of the effective date of any workers' compensation policy or within thirty (30) days of the date of extension, renewal, reinstatement or amendment to such policy.

(2) Every insurer shall, in the event of a policy cancellation, file a notice of cancellation with the workers' compensation administration within 10 days of such cancellation.

(3) Vendor certification

(a) In order to be certified as a vendor for submission of POC data with the workers' compensation administration, an entity must receive certification from the workers' compensation administration.

(b) In order to maintain certified vendor status, the vendor must maintain certification with the workers' compensation administration, which includes continuous compliance with the workers' compensation administration POC business plan.

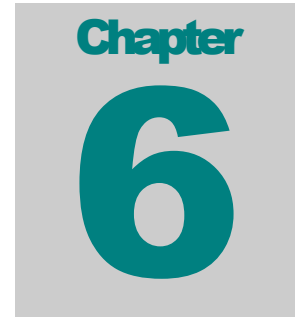
B. POC submission procedures and requirements

(1) POC data must be submitted in the IAIABC POC flat file format.

(2) A vendor must provide optional ways for insurers to submit POC data to the vendor such as hard copy, mag tape, web page form or IAIABC flat file.

(3) Once certified, vendors must notify the workers' compensation administration of any changes they make in hardware or software and complete re-certification with the workers' compensation administration prior to using such changed or new hardware or software to submit POC data. Vendors must also comply with IAIABC requirements pertaining to hardware and software changes.

(4) A current information form and sender/vendor information form must be on file with the workers' compensation administration before electronic filings will be accepted.



**TITLE 11 LABOR AND WORKERS COMPENSATION**  
**CHAPTER 4 WORKERS' COMPENSATION**  
**PART 11 PROOF OF COVERAGE**

(5) All POC data is the property of the New Mexico workers' compensation administration and such data cannot be used for any purpose other than that designated by the workers' compensation administration.

(6) Failure to file POC data in accordance with the act and these rules will subject the insurer to penalties and fines permitted by the act and the rules.

(7) After notice and opportunity to be heard, the director may decertify a vendor for good cause shown.

C. Exempt entities:

(1) The legislatively mandated pools governed by 11 NMAC 4.10 are required to provide membership information to the workers' compensation administration through the self-insurance bureau and may exempt themselves from the electronic filing requirements at their option.

(2) Self-insurance groups, authorized to provide workers' compensation insurance to their members based upon a valid and active certificate of self-insurance issued by the director of the workers' compensation administration and whose membership roster does not exceed seventy-five (75) members are required to provide membership information to the workers' compensation administration through the self-insurance bureau and may exempt themselves from the electronic filing requirements at their option.

(3) Individual self-insurers in possession of a valid and active certificate of self-insurance issued by the director of the workers' compensation administration and those subsidiaries listed on such certificate are exempt from the filing requirements.  
 [8/1/96; 11.4.11.8 NMAC – Rn & A, 11 NMAC 4.11.8, 8/1/03]

**HISTORY OF 11.4.11 NMAC:** [RESERVED]