STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

____, WCA No.:__________________
Worker,

v.

____, and
Uninsured Employer,

STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND,
Statutory Third Party.

WORKERS' COMPENSATION COMPLAINT

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

   Mailing address: ____

   City/State/Zip: ____

   Telephone: ____

   E-mail address: ____

   Worker's highest level of school completed: ______________________________

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

   Worker's Social Security Number: _____________
3. Full name of Employer: ____

   Employer's address: ____

   City/State/Zip: ____

   Telephone: ____

   E-mail address: ____
4. Statutory Third Party: STATE OF NEW MEXICO UNINSURED EMPLOYERS' FUND

   Address: 2410 Centre Avenue SE

   City/State/Zip: Albuquerque, NM 87106

   Telephone: 505-841-6000

   E-mail address: WCA-UEF@state.nm.us

5. Date of accident: ____

   City and county of accident: ____

   How did the accident occur: ____

   Nature of injury: ____

   Part(s) of body injured: ____

   First date Worker was unable to perform job duties: _________________________________

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

   Worker's average weekly wage: ____

   Worker's weekly compensation rate: ____

7. Doctor's name: ____

   Mailing address: ____

   City/State/Zip: ____

   Telephone: ____

8. Doctor who set maximum medical improvement: ___________________________________

   Date of maximum medical improvement: ____

   Impairment rating: __________________   Date assessed: ____________________________

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

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

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

   If yes, please indicate date Worker returned to work: _____________________________

9. Current Employer's name: ____

   Mailing address: ____

   City/State/Zip: ____

10. 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)

11. Benefits or relief sought by Worker:

___ Temporary total disability
___ Permanent total disability
___ Permanent partial disability
___ Death benefits
___ Attorney fees
___ Disfigurement
___ Safety device increase (name device):____
___ Mental impairment: ___ Primary ___ Secondary
___ Medical benefits (list here or attach unpaid bills): ____________________________________
___ Determination of: ___ Bad Faith/Unfair Claims Processing ___ Fraud or ___ Retaliation
___ Other (specify):

12. Complaints by Employer:

___ Determination of compensability/benefits
___ Safety device decrease (name device):____
___ Reimbursement right
___ Credit for overpayment
___ Suspension or reduction of benefits (state grounds):

___ Other (specify):

13. State all reasons supporting this complaint (be specific; use additional pages, if necessary):

14. Is an interpreter needed for hearings on this complaint? ___ Yes ___ No

If yes, what language? ____

(Employer will pay for cost of interpreter)

15. WCA Field Office needed for Mediation? ___ Yes ___ No (If yes, please check all that apply)

___ Farmington ___ Hobbs ___ Las Cruces ___ Las Vegas ___ Roswell ___ Santa Fe

____
Filing party signature Date

____
Print name

____
Attorney's signature Date

____
Print name

____
Filing party /attorney's address

____
Filing party /attorney's city, state, zip

____
Filing party /attorney's telephone

____
Filing party / attorney's e-mail address for service

INSTRUCTIONS FOR USE: A Summons for each responding party shall be filed with this Complaint.

If the Worker is filing this Complaint, the Worker shall also complete and attach the Worker's Authorization for Use and Disclosure of Health Records.

Parties with questions may call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.