

**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:
- ___ 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.
 - ___ 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.
 - ___ Lump sum settlement payment pursuant to Section 52-5-12(D). Must be filed jointly by the Worker and Employer/Insurer.
- B. FACTUAL INFORMATION:**
- Type of injury: ___ Accidental Work Injury ___ Occupational Disease
 - 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.: _____
 - 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)

12. Is Worker currently subject to a lien for past due child support enforcing a District Court Order?

Yes No

If yes, what is the current amount owed? _____

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.