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)

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.

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

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_____,
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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