State of New Mexico Workers' Compensation Administration

# WORKERS' COMPENSATION ACT

## If You Are Injured At Work
## Si Se Lastima En El Trabajo

1) **Notice --** In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) **You have the right** to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) **Claims information --** Contact your employer's Claims Representative (see box below).

1) **Aviso. --** En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) **Usted tiene el derecho** a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) **Información acerca de Reclamaciones. --** Contáctese con el representante de reclamaciones de su compañía.

**Employer's Insurer / Claims Representative:**

Name: Next Level Administrators
Phone #: 1-877-306-6398
Address: P.O. BOX 1061
Bradenton, FL 34206

Note: Employer must fill in insurer / claims representative information.

GREAT SEAL OF THE STATE OF NEW MEXICO
CRESCIT EUNDO
1912

## YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

## SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

**Ombudsmen are located at the following offices:**

| Albuquerque: | Farmington: | Hobbs: | Las Cruces: | Las Vegas: | Roswell: | Santa Fe: |
|---|---|---|---|---|---|---|
| 1-866-967-5667 | 1-800-568-7310 | 1-800-934-2450 | 1-800-870-6826 | 1-800-281-7889 | 1-866-311-8587 | 1-505-476-7381 |
| 1-505-841-6000 | 1-505-599-9746 | 1-575-397-3425 | 1-575-524-6246 | 1-505-454-9251 | 1-575-623-3997 | |

## If You Need HELP Call:
*Ask for an Ombudsman*
## Si Usted Necesita Ayuda Llame Al:
*Pregunte por un Ombudsman*
## 1-866-WORKOMP (1-866-967-5667)
**Visit our website at: https://workerscomp.nm.gov**

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

**USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR**

**EMPLOYER: You are required by law to display this poster where your employees can read it. Post the Notice of Accident forms with it. The poster without the Notice of Accident forms does not comply with law. You have other rights and duties under the law.**

POST FORMS HERE

Rev. 11/18

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
PO Box 27198, Albuquerque, New Mexico 87125-7198

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# NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
# NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
*Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11*

I, ____________________________________________, was involved in an on-the-job accident or was disabled
*Yo,* (name of employee/*nombre del empleado*) *me lastimé en un accidente en el trabajo o fui incapacitado*

by an occupational disease at approximately ___________, on _______________, 20_____.
*por enfermedad de oficio aproximadamente* (time/*a la(s) hora(s)*) *el* (date/*fecha*) *del 20_____.*

Employee's social security number: ____________________
*Número de seguro social del empleado:*

Where did the accident occur? ______________________________
*¿Dónde ocurrió el accidente?*

What happened?______________________________________________________________________________
*¿Qué ocurrió?*
____________________________________________________________________________________________

____________________________________________________________________________________________

**To be completed by Employer:**
*Completado por el empleador:*

**Worker will choose health care provider. Yes___ No___**
*Trabajador elegirá proveedor de atención médica.*

**If Yes, Employer has right to change health care provider after 60 days.**
*En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*

**If No, Worker has the right to change health care provider after 60 days.**
*En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*

**WORKER'S INITIALS ____ *INICIALES DEL TRABAJADOR***

Signed: ______________________________________
*Firma:* (employee/*empleado*)
Date/Fecha: __________________

Signed/Notice Received: ______________________________
*Firma/Notificación recibida:* (employer or representative/*empleador o representante*)
Date/*Fecha*: __________________

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
PREVIOUS NOA FORMS ARE STILL VALID FOR USE

**Form NOA-1**

**Employer/employee: Each keep one copy.**
**Empleador/empleado: Retener una copia.**

**----SEE BACK OF THIS FORM----**
**----VER AL REVERSO DE ESTA FORMA--**

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**Worker --**
For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

***Trabajador***
*Para emergencias médicas vaya a cualquier clinica / hospital.*

*Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de dias festivos.*

**Statewide Helpline -- *Linea de Asistencia***

## 1-866-WORKOMP / 1-866-967-5667

**toll free -- *llamada sin costo de larga distancia***
**New Mexico Workers' Compensation Administration**
**PO Box 27198, Albuquerque, NM 87125**

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Hobbs: (575) 397-3425 - 1 (800) 934-2450
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381

# NOTICE TO EMPLOYEES

Pursuant to: NRS 616B.227 Election by employee to report his tips; effect; regulation.

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

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