STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

ELECTION TO BE SUBJECT TO WORKERS' COMPENSATION ACT
AND OCCUPATIONAL DISEASE DISABLEMENT LAW

_____ (Please clearly print name of employer), pursuant to NMSA 1978 §52-1-6 and §52-3-5, hereby elects to be subject to the provisions of the New Mexico Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law, including the requirements regarding obtaining and reporting insurance coverage under NMSA 1978 § 52-1-4.

The undersigned swears or affirms, under penalty of perjury, that he/she is authorized to file this election with the Workers' Compensation Administration on behalf of the above-named employer.

Signature: _____ UI Number: _____

Print name: _____ FEIN Number: _____

Title: _____ PhoneNumber: _____

Business Address: _____ City/State/Zip: _____

STATE OF _____)
)SS.
COUNTY OF _____)

SUBSCRIBED AND SWORN OR AFFIRMED to before me on the _____ day of _____, 20_____ by _____ .

_____
Notary Public

My commission expires:

_____

Please retain a copy of this form for your records.

12/2017