



PIE INSURANCE

How to respond to a workplace injury:

For life-threatening medical emergencies, call **911**.

For non-life-threatening injuries, call the **24/7 Nurse Line at (844) 581-0828** to report the incident and get your employee the right care



Workers' comp claims

You can file your first report of injury for a workers' comp claim in three simple ways:

Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

[Submit the claim information online here](#)

Email the claims team within 24 hours of the incident: **claims@pieinsurance.com**

- **In your email, please include the following:**
- The name of your business
- The policy number
- Reporting party's contact information (name, phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

Thank you.



pieinsurance.com

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.

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: Pie Insurance
Phone #: (844) 581-0828 claims@pieinsurance.com
Address: PO Box 30018
Salt Lake City, UT 84130-0018

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

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PART 1 OF 2
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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.

Ombudsmen are located at the following offices:

Albuquerque:
1-866-967-5667
1-505-841-6000

Farmington:
1-800-568-7310
1-505-599-9746

Hobbs:
1-800-934-2450
1-575-397-3425

Las Cruces:
1-800-870-6826
1-575-524-6246

Las Vegas:
1-800-281-7889
1-505-454-9251

Roswell:
1-866-311-8587
1-575-623-3997

Santa Fe:
1-505-476-7381

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.

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PART 2 OF 2



If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (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 post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.



Workers' Compensation

Fraud is a CRIME

**To report fraud call
(505) 841-6832 or
1-800-255-7965**



NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER / ADMINISTRATOR CLAIM #		OSHA LOG NUMBER		REPORT PURPOSE CODE				
					JURISDICTION		JURISDICTION CLAIM NUMBER						
					INSURED REPORT NUMBER								
	PHONE NUMBER				EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #			
									INDUSTRY CODE				
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
		CARRIER FEIN				POLICY / SELF-INSURED NUMBER				ADMINISTRATOR FEIN			
		AGENT NAME & CODE NUMBER											
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE		
	ADDRESS (INCL ZIP)				GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN		MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN		OCCUPATION/JOB TITLE OR (SOC) CODE				
	PHONE NUMBER				# OF DEPENDENTS				EMPLOYMENT STATUS				
									NCCI CLASS CODE				
W A G E	RATE		PER:		☐ DAY ☐ WEEK	☐ MONTH ☐ OTHER:	# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		☐ YES ☐ NO	☐ YES ☐ NO	
									DID SALARY CONTINUE?		☐ YES ☐ NO	☐ YES ☐ NO	
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		☐ AM ☐ PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE ☐ AM ☐ PM		LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
	CONTACT NAME / PHONE NUMBER						TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO						TYPE OF INJURY / ILLNESS CODE				PART OF BODY AFFECTED CODE		
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
	HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.												
											CAUSE OF INJURY CODE		
	DATE RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				☐ YES ☐ NO ☐ YES ☐ NO				
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)						HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSPITAL ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
O T H E R	WITNESSES (NAME & PHONE #)												
	DATE ADMINISTRATOR NOTIFIED				DATE PREPARED		PREPARER'S NAME & TITLE						

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000

In-State Toll Free: 1-800-255-7965

FARMINGTON: 599-9746/1-800-568-7310

LAS CRUCES: 524-6246/1-800-870-6826

LAS VEGAS: 454-9251/1-800-281-7889

LOVINGTON: 396-3437/1-800-934-2450

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to \$1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication ***Guide to Completing the Employer's First Report of Injury or Illness***, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits*.

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).