STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

CLAIM FOR UNINSURED EMPLOYERS' FUND BENEFITS

1. Worker's Full Name:______________________________
2. Mailing Address:______________________________
3. City/State/Zip:______________________________
4. Telephone No.:__( )______________________________
4. Worker's Date of Birth:______________________________
5. Worker's Social Security No.:______________________________
6. Full Name of Job Accident Employer:______________________________
7. Employer's Address:______________________________
8. City/State/Zip:______________________________
9. Telephone No.:___( )______________________________
10. Date of Accident:______________________________
    a. City and County of Accident:______________________________
    b. Worker's Job Title at Time of Accident:______________________________
    c. How did the Job Accident Occur?______________________________
    ____
    d. Part (s) of Body Injured?______________________________
    e. Name and Address of Treating Doctor?______________________________
    ____

____
Worker's Name (Print)

____
Name/Address of Worker's Attorney/Rep.

____
Worker's Signature Date

____

Return Completed Form To: WCA/Uninsured Employer Fund, P.O. Box 27198, Albuq, NM 87125-7198