

**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 \_\_\_\_\_.

My commission expires: \_\_\_\_\_ Notary Public