STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

EXECUTIVE EMPLOYEE AFFIRMATIVE ELECTION FORM

I, _____ (Please print name), am a "worker" as defined in the New Mexico Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law ("the Acts"). I am employed by _____ (Name of corporation or limited liability company), a company subject to the provisions of the Acts. Pursuant to NMSA 1978, §52-1-7 or §52-3-6, I affirmatively elect **NOT TO ACCEPT** the provisions of the Acts. I meet the qualifications set forth in §52-1-7 or §52-3-6 as follows:

- I am the chairperson of the board, president, vice president, secretary, treasurer, or other executive officer of the employer corporation or limited liability company; and
- I own ten percent or more of the outstanding stock of the employer corporation or have at least a ten percent ownership interest in the employer limited liability company

If my business is licensed with the Construction Industries Division or is engaged in business activities that fall under the Construction Industries Licensing Act I understand that all employees, including those hired on a temporary basis, are required to be covered by workers' compensation insurance unless they are an executive employee and have filed an affirmative election form to not accept the provisions of the Act.

I understand that I may face significant monetary penalties, up to $1,000 for each occurrence, and that my business may be shut down, if my business fails to secure workers' compensation insurance when it is required. I also understand that if my business fails to obtain workers' compensation insurance when it is required to, I may be responsible for the costs associated with any claim for workers' compensation benefits, including the costs of medical and disability payments.

I understand that by making this affirmative election, it applies to all corporations or limited liability companies in which I have a financial interest. I understand that if I wish to revoke my election, I am required by law to file a revocation with my insurance carrier and with the Workers' Compensation ("WCA") Director's Office, and to mail a copy of the revocation to the board of directors of employer corporation or limited liability company. I also agree to notify the WCA of any changes in my §52-1-7 or §52-3-6 status.

I further understand that by making this election not to accept the provisions of the Acts, I will not be entitled to workers' compensation benefits from the Uninsured Employers' Fund.

I swear or affirm under penalty of perjury that I have read the foregoing affirmative election in its entirety and understand the information contained therein is true and correct to the best of my knowledge.

Signature: _____ UI Number: _____

Executive Title: _____ FEIN Number: _____

Business Address: _____ Phone Number: _____

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.

10/4/11