State Accident Fund

Mileage Reimbursement Form

Injured Worker Name: _____

Home address: _____ Claim #:_____

Employer: Clemson University Date of Accident: _____

Mileage must be more than 10 miles round trip *Mileage will not be paid for travel to the drug store*

Rate: 01/01/01-6/30/06= .345;07/01/06-06/30/08=.445; 07/01/08-12/31/09= .505;
01/01/10-12/31/10=.50; 01/01/11-6/30/2012= .505; 07/01/20125-12/31/2012= .555
Effective 01/01/2013= .565

Date of Trip	Please include the following: From: full address (street, city, state, zip code) To: full address of the facility/doctor(street, city, state, zip code)	Round Trip Miles	Rate	Total **SAF** use only
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			

Signature of Injured Worker:_____ Date:_____

Remit to: State Accident Fund Post Office Box 102100 Columbia, South Carolina 29221-5000

For additional copies, please visit our website **www.saf.sc.gov**

State Fund will compare all submitted roundtrip mileage to MapQuest Driving Directions. It is recommended that you wait at least 30 days before submitting mileage so the proper documentation can be received from the Physician's office.

If this form is not completed in its entirety it will be returned.