

State Accident Fund  
**Mileage Reimbursement Form**

**Injured Worker Name:** clmt  
**Home Address:** addr  
**Employer:** employer

**Claim No:** cno

**Date of Accident:** doi

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

**Rate: 01/01/01 - 06/30/06 = .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 - 06/30/2012 = .505; 07/01/2012 - 12/31/2012 = .555  
 01/01/2013 - 12/31/2103 = .565; 01/01/2014 - 12/31/2014 = .56; 01/01/2015 - present = .575**

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:			
	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](http://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.**