State Accident Fund

Mileage Reimbursement Form

Injured Worker Name: ___________________________________________  Claim #: __________________
Home address: _____________________________________________________________________________

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:

1/1/01-6/30/06 = .345;  7/1/06-6/30/08 = .445;  7/1/08-12/31/09 = .505;  1/1/10-12/31/10 = .50;
1/1/11-6/30/2012 = .505;  7/1/2012-12/31/2012 = .555;  1/1/2013-12/31/2013 = .565;  1/1/2014-12/31/2014 = .56;
1/1/2015-12/31/2016 = .575;  1/1/2016-12/31/2016 = .54;  Effective 1/1/2017 = .535

<table>
<thead>
<tr>
<th>Date of Trip</th>
<th>Please include the following: From: full address (street, city, state, zip code)</th>
<th>Round Trip Miles</th>
<th>Rate</th>
<th>Total SAF use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>To: full address of the facility/doctor (street, city, state, zip code)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>To:</td>
<td></td>
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</tr>
</tbody>
</table>

Signature of Injured Worker: _______________________________  Date: ______________

Remit to: Risk Management, E-306 Martin Hall, Clemson, SC 29634. Please make additional copies as needed.

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.