

State Accident Fund
Mileage Reimbursement Form

Injured Worker Name:
Home Address:
Employer: CLEMSON UNIVERSITY

Claim No:
Date of Accident:

Mileage must be more than 10 miles round trip
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 – 12/31/2013 = .565; 01/01/2014 – 12/31/2014 = .56; 01/01/2015 – 12/31/2015 = .575;
01/01/2016 – 12/31/2016 = .54; ; 01/01/2017 – 12/31/2017 = .535; 01/01/2018 – 12/31/2018 = .545;
01/01/2019 – 12/31/2019 = .58; 01/01/2020 to 12/31/2020 = .575; 01/01/2021 to present = .56

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: Clemson University Risk Services 391 College Ave, Ste 202, Clemson, SC 29634
 email to: wriskmanagement@clemson.edu or fax to: 864-656-4558

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

State Fund will compare all submitted roundtrip mileage to Google Maps 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.