State Accident Fund
Mileage Reimbursement Form

Injured Worker Name: 
Home Address: 
Employer: 

Claim No: 
Date of Accident: 

*Mileage must be more than 10 miles round trip*
Rate: 01/01/2017 - 12/31/2017 = .535; 01/01/2018 - 12/31/2018 = .545; 01/01/2019 - 12/31/2019 = .58;
01/01/2020 - 12/31/2020 = .575; 01/01/2021 - 12/31/2021 = .56; 01/01/2022 - 6/30/2022 = .585;
7/1/2022 - 12/31/2022 = .625; 01/01/2023 - 12/31/2023= .655; 01/01/2024 - Present = .67

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

Signature of Injured Worker: ___________________________ Date: _______________________

Remit to: State Accident Fund, Post Office Box 1166, Lexington, South Carolina 29071

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.