Trindel Insurance Fund

MILEAGE REIMBURSEMENT CLAIM FORM

CLAIMANT'S NAME: _____ CLAIM NUMBER: _____

EMPLOYER: _____

You are entitled to be reimbursed for mileage expenses associated with trips to and from your medical appointments, to pick up prescriptions, parking, bridge tolls, and public transportation costs that you incur for your indurstrial injury.

To request your reimbursement, please complete this form, attach any receipts you have, and mail to:
Trindel Insurance Fund P.O. Box 2069, Weaverville, CA 96093.

If you have any questions, please call us at (530) 623-2322

Mileage rates vary depending on the day you traveled. The total due to you will be based using the round-trip miles traveled.

Date of Travel	Mileage Rate
01/01/18 - Present	.545 PER MILE
01/01/17 - 12/31/17	.535 PER MILE
01/01/16 - 12/31/16	.54 PER MILE
01/01/15 - 12/31/15	.575 PER MILE
01/01/14-12/31/14	.56 PER MILE
01/01/13-12/31/13	.565 PER MILE

Date Traveled	Traveled From	Traveled To	Round Trip Mileage	Do Not write in this column
Example 01/07/12	**Physical Address City, State, Zip**	**Doctor/Facility name Physical Address, City, State, Zip**	**14 mi**	
			Total Reimbursement	

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.
I declare under penalty of perjury that the above is true and correct.

Signed: _____ Date: _____

Print Name: _____

Address: _____