Clearview LSD Employee Name:_____

Clearview Local Schools

Your employee _____, is entitled to medical health insurance cost reimbursement through a spousal coverage benefit allowance with the Clearview Local Schools.

What did your employee pay for **single medical** insurance from Sept. 1 to Aug. 31 _____
[excludes dental, vision, life, etc.]

What was the monthly premium deduction for **single medical insurance only** _____
[excludes dental, vision, life, etc.]

How many premium deductions were made for this employee at the cost listed above? _____

_____
Employer Name

_____ _____
Employer Address *Telephone*

_____ _____
Person completing this form. *Title* *Date*

Return form by: September 1

To: Mary Ann Nowak, Treasurer/CFO
Clearview Local Schools
4700 Broadway Avenue
Lorain, OH 44052-5542

Approved_____ **Date**_____

The Clearview Local Schools will only reimburse for single medical coverage. Aforementioned exclusions apply.
IF THIS FORM IS NOT COMPLETED IN ITS ENTIRETY, THERE WILL BE A DELAY IN THE REIMBURSEMENT.