


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*

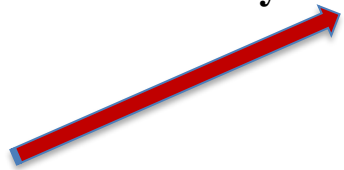
\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*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.**