COMBINED
A Chubb Company

COMBINED
Une compagnie de Chubb

Claim #

CERTIFICATE OF EMPLOYER

I hereby certify that: MR. ☐ MRS. ☐ MS. ☐ MISS ☐

First Middle Last

Was absent from work from: Day/Month/Year _____ to Day/Month/Year _____ (Inclusive)

He (she) was first able to resume part of his (her) duties on: _____

And all of his (her) duties on: _____

His (her) occupation and daily duties are as follows:

If the loss of time is due to an accident at work, please give the date and a detailed description of the accident.

Company Stamp (with full name, address and telephone number)

Name Position

Signature of Employer

Telephone No. Fax No.

Date

Combined Insurance Company of America / Compagnie d'assurance Combined d'Amérique
Home Office / Siège social : Chicago, Illinois 60640
Canadian Head Office / Siège social canadien : P.O. Box 3720, MIP, Markham (Ontario) L3R 0X5
Telephone / Téléphone : 1 888 234-4466 Fax Number / Numéro de télécopieur : 905 754-4362
www.combined.ca
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