BCTF Salary Indemnity Plan —Short-term

100-550 West 6th Avenue, Vancouver, BC V5Z 4PZ | Phone: 1-800-663-9163 | 604-871-1921 | Fax: 604-871-2287 | Email: benefits@bctf.ca

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Short-term—Declaration of Claimant—Injury or illness claim—page 1 of 3

Return completed forms by:
Email: *benefits@bctf.ca*
Fax: 604-871-2287
Mail: 100–550 West 6th Avenue
Vancouver, BC V5Z 4P2

Name: _____, _____
surname *first name*

Previous surname: _____

I identify as:

☐ Man ☐ Woman ☐ Non-binary ☐ Two Spirited ☐ other term (specify): _____ ☐ prefer not to answer

Date of birth: _____ _____, _____ Social Insurance Number: _____
month *day* *year*

Teacher Certificate number: L_____ Total number of years teaching: _____
To retrieve your teaching certificate number, go to:
teacherregulation.gov.bc.ca/LoginInfo/YourAccountLogin

Mailing address: _____ City _____ Postal code_____

Personal email: _____

Home phone: _____ Cell phone: _____

School districts (SD) no. and school(s) **currently** employed (list all):

SD no.	School name	Position(s) held

Are any of these schools on an alternative school calendar (i.e., year-round school): ☐ No ☐ Yes

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Working part-time, self-employed, or work-hardening—please complete the Accommodation employment application:

Are you employed elsewhere, or self-employed? ☐ No ☐ Yes—If yes, please specify name of employer and describe duties:

_____

Current volunteer activities, clubs, etc.: _____

Course work—are currently enrolled in any course work: ☐ No ☐ Yes—please provide details (name of courses or program):

_____

Start and end date: _____ Institution: _____

Without authorization from the Plan Administrator, I agree I will not become employed or earn any income (other than investment income).

Please initial: X_____

Date Received by BCTF Income Security Division

Short-term—Declaration of claimant—Injury or illness claim—Page 2

Name: _____, _____ Social Insurance Number: _____ SD no.: _____
Surname *Legal first name*

The exact nature/cause of illness or injury: _____

_____

_____

_____

Dates absent from work: _____ _____, 20____ to _____ _____, 20____
month *day* *year* *month* *day* *year*

My absence from illness/injury is continuing? ☐ Yes ☐ No—if no, date returned to work: _____ _____, 20____
month *day* *year*

Name(s) of all doctors consulted during present disability:

Doctor Name	Type of Doctor (GP, specialty, etc.)

I was teaching in British Columbia last school year from: _____ _____, 20____ to _____ _____, 20____
month *day* *year* *month* *day* *year*

and/or

I was on leave of absence last school year from: _____ ____, 20____ to _____ ____, 20____
month *day* *year* *month* *day* *year*

Are you in receipt of a pension from Teacher's Pension Plan? ☐ No ☐ Yes $_____ (gross monthly amount)

Are you in receipt of Canada Pension Plan? ☐ No ☐ Yes $_____ (gross monthly amount)

Workers' Compensation Board (WorkSafeBC) claim information (if applicable, please complete the form found here):

I am applying for, or have applied for, Worker's Compensation benefits for this illness or injury. ☐ No ☐ Yes

I am in receipt of WorkSafeBC for this illness or injury. ☐ No ☐ Yes

If yes—please include/forward your WorkSafeBC approval/decision letter.

Are you in receipt of a WorkSafeBC pension/disability award? ☐ No ☐ Yes $_____
(gross monthly amount)

Is ICBC or another insurer involved in this claim: ☐ No ☐ Yes

I have attached a void cheque/banking information. **Please initial: X**_____

I have attached a copy of my most recent **TPP Annual Member's Benefit Statement.** **Please initial: X**_____
You can access your account here: *tpp.pensionsbc.ca*

I hereby declare that the above information is true: **Please initial: X**_____

Name: _____, _____ Social Insurance Number: _____ SD no.: _____
Surname *Legal first name*

I hereby consent for the Salary Indemnity Plan to use my social insurance number for the purposes of reporting Pension Service to the Teachers' Pension Plan. ☐ No ☐ Yes

Informed consent and release of information:

- I hereby authorize the British Columbia Teachers' Federation (BCTF) Salary Indemnity Plan and its representatives to obtain, release, and discuss information reasonably related to my claim and/or rehabilitation including any and all reports and information regarding medical status to: my family physician, medical specialists, licensed physicians performing independent medical examinations, BCTF Salary Indemnity Plan representatives, BCTF Workers' Compensation Board (WorkSafeBC) advocate, Canada Life Insurance Company representatives, rehabilitation consultants from assigned rehabilitation service providers, BCTF local union representatives and to other professionals involved in my rehabilitation and/or claim adjudication.
- I hereby authorize the BCTF Salary Indemnity Plan and its representatives to obtain and release information to the BCTF/employer group life insurance provider in order to facilitate a waiver of premiums for my life insurance benefits.
- I hereby authorize the BCTF Salary Indemnity Plan and its representatives to advise BCTF local union representatives and my employer on my short-term and long-term SIP status and when I am approaching the anticipated end date of my benefits.
- I hereby consent for my employer(s) to release information regarding my contract, income, status, or any other required information.
- I hereby consent for BCTF Member Records to exchange information with the BCTF Salary Indemnity Plan regarding my contract, income, status, or any other required information.
- I hereby consent for the BC Pension Corporation to release information regarding my service.

Date:_____ _____, 20_____ **Signature of claimant:** **X**_____
month *day* *year*

Note: *for authorization purposes, if completing online, add electronic signature or type name unless, if* **not** *attaching TPP annual statement, then only physical signature is acceptable.*

By furnishing this form and investigating this claim, the Board of Trustees of the BCTF Salary Indemnity Trust shall not be held to admit validity of any claim or waive the breach of any condition of the bylaws of the Federation governing the Salary Indemnity Plan.

Note: The Salary Indemnity Plan is not insured by an insurance company regulated under the *Financial Institutions Act*. The BCTF is exempt from the regulatory requirements of the *Financial Institutions Act.*

Regulations of the Salary Indemnity Plan are contained in the Members' Guide to the BCTF and can be found here.

IMPORTANT

All banking and Teachers' Pension Plan (TPP) information must be provided in order to process your claim.

SIP short-term disability benefits will only be deposited into your bank, trust company, or credit union account.

Please attach a copy of your voided cheque or direct deposit form available from your branch or through your online banking app and a copy of the most recent pension statement.

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