

CLAIMING FOR INTERMITTENT ABSENCES

Maximum of five (5) per school year

If you have exhausted all your available sick leave from your school board and have the occasional or intermittent absence(s) (up to five per school year) for which you have not been paid by your school board, you may be eligible to claim for benefits from the Salary Indemnity Plan (SIP).

Intermittent absences are defined as absences which occur at irregular intervals.

Absences beyond these five days will require an SIP *Short-term Certificate of attending physician* form to be completed by your physician and submitted along with your completed *Short-term Declaration of claimant* form. Forms can be found at:

www.bctf.ca/services-guidance/benefits/salary-indemnity-plan/apply-for-salary-indemnity-plan

Here are a few things you should be aware of:

- To claim for intermittent absences, you must qualify in the usual manner as per *SIP Regulations 1* and *9*. For a copy of the September 1, 2025, *SIP Regulations* go to:
www.bctf.ca/docs/default-source/services-guidance/benefits/sip-regulations.pdf
- Each claim requires a completed *Short-term—Declaration of claimant* form; this is your application for benefits: www.bctf.ca/docs/default-source/services-guidance/sip-application-form.pdf
- Your claim must be for dates that have already occurred.
- Once you have been issued a benefit for the dates you claimed and have returned to work, your claim will be closed, and you must re-apply for any additional absences with a whole new set of forms.
- You may choose to apply after each absence, once a month, or save them up and apply once or twice yearly.
- The grid on the following page may be used to report your absences that you would like covered by SIP. You are not required to have a *Short-term—Certificate of attending physician* form completed for SIP: Short-term coverage for up to five intermittent absences per school year.
- Please note, for intermittent absences claims, you must indicate the specific date that you were not paid by your employer for an unpaid sick leave absence that was due to personal illness or injury.

INTERMITTENT ABSENCES

I hereby certify that I was prevented, due to illness or injury on the following dates, from performing my normal employment duties and that I was not paid by my school district for these absences.

Date(s)

Signature of member

*Note: Type name if completing online for authorization purposes.

Date

Name (please print)

Street

City/province/postal code

Phone number

This form must be fully completed and submitted along with a completed declaration of claimant form before benefits can be issued from the BCTF Salary Indemnity Plan.

Return completed form via:

Email: benefits@bctf.ca

Fax: 604-871-2287

Mail: 100-550 West 6th Avenue
Vancouver, BC V5Z 4P2



Salary Indemnity Plan —Short-term

100-550 West 6th Avenue, Vancouver, BC V5Z 4P2 | 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

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: _____
month *day* *year* Social Insurance Number: _____

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

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 _____

Return completed forms by:

Email: benefits@bctf.ca

Fax: 604-871-2287

Mail: 100-550 West 6th Avenue
Vancouver, BC V5Z 4P2

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____
month day year

Signature of claimant: **X** _____
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.
