Salary Indemnity Plan—Short-term

100–550 West 6th Avenue, Vancouver, BC V5Z 4P2 • 604-871-1921 • 1-800-663-9163 • Fax 604-871-2287 • email: benefits@bctf.ca

Short-term—Declaration of claimant—Injury or illness claim—Page 1 of 2

Please print

Social Insurance Number: ______________________________ Date of birth: ______________________________

Title: ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Other (specify) ______________________________

Name: ______________________________ Previous/birth name: ______________________________

Mailing address: ______________________________

City: ______________________ Postal code: ______________________ Home phone: ______________________

Personal Email address: ______________________________ Cell phone: ______________________

School District (SD) name and number: ______________________________

School: ______________________________ Is this school on an alternative school calendar? ☐ Yes ☐ No

Years of teaching: ______________________________

Describe briefly your recent work assignments (i.e., teaching, counseling, administration, grade levels, subject areas, etc.):

____

____

Current Volunteer activities, clubs, etc.: ______________________________

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

____

____

Are you currently enrolled in any post-graduate course work? ☐ No ☐ Yes

If yes, complete and submit the Course Work Application form as authorization must be obtained from the Plan Administrator.

The exact nature/cause of my illness or injury is/was: ______________________________

____

____

because of which I was absent from working from: ______________ to ______________ 20______
date date

My absence because of illness or injury is continuing? ☐ Yes ☐ No

If no, I returned to teaching duty on: ______________________________

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

____

____

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

I am in receipt of Worker's Compensation for this illness or injury. ☐ Yes ☐ No

If yes, please forward your Workers' Compensation Board (WorkSafeBC) approval letter.

Are you in receipt of a Workers' Compensation Board (WorkSafeBC) pension/disability award? ☐ Yes ☐ No

Please complete attached form re: Workers' Compensation Board (WorkSafeBC) claim information (if applicable).

ICBC or other insurer involved in this accident: ☐ Yes ☐ No

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*.

Date received by BCTF Income Security Division

Please turn over and complete page 2

BCTF | Salary Indemnity Plan—Short-term

100–550 West 6th Avenue, Vancouver, BC V5Z 4P2 • 604-871-1921 • 1-800-663-9163 • Fax 604-871-2287 • email: benefits@bctf.ca

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

Please print

Claimant name:______________________________ SIN: __________________ SD no.:____________

I was teaching in British Columbia last school year from: ____________________ to ________________________
and/or
I was on leave of absence last school year from: ________________________ to________________________

I agree to participate in any vocational rehabilitation program that has been approved by my doctor and Salary Indemnity Plan Administrator: ☐ Yes ☐ No

Please complete the enclosed form **Accommodation employment/Volunteer Work Application** if you are currently working part time, work hardening, or are engaged in any volunteer activities.

Without authorization from the Plan Administrator, I agree I will not:

1. become employed, volunteer or earn any income (other than investment income)
2. retrain or do course work.

Please initial: **X**____________________ *Note: Type initials if completing online for authorization purposes*

Are you in receipt of a pension from Teacher's Pension Plan? ☐ Yes ☐ No

If yes, please provide monthly gross amount: ____

Are you in receipt of Canada Pension Plan? ☐ Yes ☐ No

If yes, please provide monthly gross amount: ____

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: ☐ Yes ☐ No

I hereby declare that the above information is true: ☐ Yes ☐ No

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 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**______________________________

Note: Type name if completing online for authorization purposes.

By furnishing this form and investigating this claim, the Income Security Committee 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.

Regulations of the Salary Indemnity Plan are contained in the *Members' Guide to the BCTF*.

PLEASE NOTE THE FOLLOWING:

All banking 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.**

AND

A copy of the most recent pension statement, which you have received from the BC Pension Corporation, must be enclosed with this application.