



# Salary Indemnity Plan—Short-term

TFEU



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 3

Return completed forms by:

Email: [benefits@bctf.ca](mailto: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](http://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:**

1. 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 of 3**

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](http://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.  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 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 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.**

**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](#).

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## 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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