



BURNABY TEACHERS' ASSOCIATION

#115-3993 HENNING DRIVE, BURNABY, B.C., V5C 6P7

Are you on BCTF Salary Indemnity Plan?

You need to know...

The BTA plan administrators of a 1981 agreement between the BTA and the Board adopted the following amendments to that plan on May 1, 2024.

As of September 3, 2024, any active BTA member who is in receipt of benefits from the BCTF Salary Indemnity Plan (either short-term or long-term) may request reimbursement from the funds remaining in the account from the agreement established in 1981. Reimbursement is only for medical expenses paid out-of-pocket which are non-reimbursable from any other source.

To access a reimbursement, the member must complete an application for consideration by the BTA members charged with administering the BTA Salary continuance/Long Term Disability plans. These members may be referred to as "plan administrators" or "trustees".

Each application for reimbursement must include receipts indicating proof of payment.

The application must provide permission from the member for the plan administrators to verify that the member is currently receiving benefits from a BCTF SIP. For privacy reasons, this information cannot be given to the plan administrators without consent of the member. Once permission to verify is given, the BTA or Board may verify participation.

Requests for reimbursement cannot be made for payment of BCTF SIP fees, EHB fees, or fees paid for other forms of medical insurance.

Requests for reimbursement may be made once per month from September through June. Attached receipts must be dated within six months of the reimbursement request. The member must have been on BCTF SIP at the time of the reimbursement being requested!

It is intended that this reimbursement plan will continue until the monies remaining in the accounts specified from 1981 are depleted. As time passes, the administrators/trustees may consider additional amendments to the reimbursement plan.

Reimbursement for out-of-pocket medical expenses, not reimbursable from other sources, and prescribed/authorized by your medical practitioner, will be considered at monthly meetings of the BTA plan administrators/trustees from September-June of each year.

In general, reimbursement will not be granted for travel, cosmetic surgery, fertility procedures, dental procedures, weight loss or gain, or gym memberships.

If you have any questions for the plan administrators/trustees, please feel free to email us at BTASalaryContinuance@gmail.com

Robyn-Mae Deang, Sharon Freeman, Graham Gertz, Patti Jukes, and Richard Storch



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The BTA Salary Continuance plan administrators/trustees will be meeting on the following dates for the 2025-2026 school year:

September 23

October 21

November 18

December 9

January 13

February 10

March 10

April 21

May 5

June 16

Applications must be received by 4:00pm on the Thursday prior to the monthly meeting date to be considered at that meeting.



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BTA Members Currently on BCTF Salary Indemnity

Reimbursement Application Information

Please complete the application form found on the BTA website in its entirety and return it (and receipts) to the plan administrators/trustees either:

a) in a sealed envelope dropped off, or mailed to, the BTA office at

#115-3993 Henning Drive, Burnaby BC V5C 6P7 or

b) by email to BTASalaryContinuance@gmail.com

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Application for Reimbursement of Out-Of-Pocket Expenses

Name (please print) _____

I am an active BTA member who is currently in receipt of benefits from the BCTF Salary Indemnity Plan (either short-term or long-term). I give my permission for the plan administrators/trustees to verify my status with the BTA or the Burnaby Board of Education.

I verify that I am out-of-pocket for the medical expenses listed and that they are not otherwise reimbursable.

I understand that, if reimbursed, I may not claim these expenses for income tax purposes.

Signed _____

Date _____

As per the "You need to know" information sheet, I am sending the following receipts for reimbursement of out-of-pocket medical expenses as authorized by my medical practitioner. These are expenses that are not covered in any other manner.

	Date Paid	Amount Paid
1		\$
2		\$
3		\$
4		\$
5		\$
	Total Requested:	\$

If approved for reimbursement, please mail my cheque to the following address:

If the plan administrators/trustees need to contact you, please indicate your preference(s) by completing the following.

Email: _____

Phone Number: _____ ☐ Text ☐ Call