HBPA of Ontario
Administrative Office
135 Queens Plate Drive, Suite 420, Toronto, Ontario M9W 6V1
Telephone: 416-747-5252 or 1-866-779-3067
Fax: 416-747-9606 / Email: general@hbpa.on.ca
Website: www.hbpa.on.ca

PENSION PLAN ENROLMENT FORM

Registration Number: 1049550

APPLICANT'S INFORMATION

LAST NAME: **FIRST NAME:** **MIDDLE NAME:**

SOCIAL INSURANCE NUMBER: **AGCO LICENSE #:**

DATE OF BIRTH: (*DD/MM/YR)* **GENDER: M☐ / ☐**

STREET ADDRESS: **APARTMENT #:**

CITY: **PROVINCE:** **POSTAL CODE:**

PHONE NUMBER: **ALTERNATE NUMBER:**

EMAIL ADDRESS:

APPLICANT'S WORK HISTORY FOR LAST TWO YEARS

Year employment began at the Woodbine or Fort Erie racetrack: _____

TRAINER'S NAME & SIGNATURE:

DATES OF EMPLOYMENT (DD/MM/YR) FROM: **TO:**

TOTAL HOURS WORKED: **LICENSED AS:**

TRAINER'S NAME & SIGNATURE:

DATES OF EMPLOYMENT *(DD/MM/YR)* FROM: **TO:**

TOTAL HOURS WORKED **LICENSED AS:**

(If there is not enough room to list your work history for the last two years, please complete the Proof of Employment Form)

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BENEFICIARY INFORMATION

LAST NAME: **FIRST NAME:** **MIDDLE NAME:**

RELATIONSHIP TO YOU:

STREET ADDRESS: **APARTMENT #:**

CITY: **PROVINCE:** **POSTAL CODE:**

PHONE NUMBER: **ALTERNATE NUMBER:**

NOTE TO APPLICANT:

All designations remain in effect until they are revoked in writing and sent to the Horsemen's Benevolent and Protective Association of Ontario (HBPA). If you have a spouse when you die, provincial legislation may stipulate that death benefits be paid to your spouse.

Please advise the HBPA if your personal circumstances such as your marital status or preferred beneficiary change.

I understand that this form is solely an application for membership in the Horsemen's Benevolent and Protective Association of Ontario Pension Plan (the "Plan") and that I will not become a member of the Plan unless my period of licensing by the Alcohol and Gaming Commission (the "Commission") has been verified and the Pension Committee has approved my application.

I understand that, although the Plan booklet sets out how HBPA intends to administer the Plan, it is possible that the Plan may have to be revised in order to be registered by the applicable authorities and no recipient of the booklet or the enrolment form is automatically entitled to benefits from the Plan.

I hereby authorize the Commission to release to the Pension Committee such information from their records as the Pension Committee may require provided such information is utilized only for the purposes of the Plan.

I understand that if I become a member of the Plan and I fail to provide information requested by the Pension Committee within the time limits established by the Pension Committee, I will immediately cease to accrue benefits under the Plan.

I understand that the Pension Committee may require information further to that which is set above.

I understand that if I become a member of the Plan and it is discovered that I have provided incorrect information to my employer, the Pension Committee or the Commission and such information was relied upon for purposes of the Plan, I will immediately cease to accrue benefits under the Plan and I will not be entitled to any benefits arising from the incorrect information.

APPLICANT'S SIGNATURE & DATE ***WITNESS SIGNATURE & DATE:***

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PROOF OF EMPLOYMENT

I certify that the following person, __________________________ was employed by my company on a FULL TIME basis from_________________ to _____________________________
(DAY/MONTH/YEAR) ***(DAY/MONTH/YEAR)***

_______________________________ _______________________________
EMPLOYER'S NAME (PLEASE PRINT) ***EMPLOYER'S SIGNATURE***

I certify that the following person, __________________________ was employed by my company on a FULL TIME basis from_________________ to _____________________________
(DAY/MONTH/YEAR) ***(DAY/MONTH/YEAR)***

_______________________________ _______________________________
EMPLOYER'S NAME (PLEASE PRINT) ***EMPLOYER'S SIGNATURE***

I certify that the following person, __________________________ was employed by my company on a FULL TIME basis from_________________ to _____________________________
(DAY/MONTH/YEAR) ***(DAY/MONTH/YEAR)***

_______________________________ _______________________________
EMPLOYER'S NAME (PLEASE PRINT) ***EMPLOYER'S SIGNATURE***

I certify that the following person, __________________________ was employed by my company on a FULL TIME basis from_________________ to _____________________________
(DAY/MONTH/YEAR) ***(DAY/MONTH/YEAR)***

_______________________________ _______________________________
EMPLOYER'S NAME (PLEASE PRINT) ***EMPLOYER'S SIGNATURE***

I certify that the following person, __________________________ was employed by my company on a FULL TIME basis from_________________ to _____________________________
(DAY/MONTH/YEAR) ***(DAY/MONTH/YEAR)***

_______________________________ _______________________________
EMPLOYER'S NAME (PLEASE PRINT) ***EMPLOYER'S SIGNATURE***

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PENSION PLAN ENROLMENT CHECKLIST

- ☐ Photocopy of valid Alcohol and Gaming Commission (AGCO) license
- ☐ Photocopy of complete licensing history from the AGCO
- ☐ Photocopy of T4s from employers for last two years which corresponds with the employment history provided on the first page of this application
- ☐ If you are self - employed and unable to supply T4s for the last two years of employment, please provide of copy of your Notice of Assessment (NOA) from the Canada Revenue Agency (CRA) for the last two years
- ☐ Completed Pension Plan Enrolment Form including hours worked, dates of employment and Trainer's Signature

Please note that this form must be completed by the applicant; incomplete forms will not be accepted by the HBPA of Ontario and will be returned to the applicant.

If you have any questions with regards to completing this form please contact the Administrative for assistance.