HBPA of Ontario
Administrative Office
135 Queen's 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 - ANNUAL RECORD OF EMPLOYMENT

REGISTRATION NUMBER: 1049550

PLAN HOLDER'S INFORMATION

LAST NAME: FIRST NAME: MIDDLE NAME:

SOCIAL INSURANCE NUMBER: AGCO LICENSE #:

DATE OF BIRTH: GENDER: M / F

STREET ADDRESS: APT #:

CITY: PROVINCE: POSTAL CODE:

PHONE NUMBER: ALTERNATE NUMBER:

EMAIL ADDRESS:

WORKING HISTORY FOR YEAR ENDED DECEMBER 31, 2020

TRAINER'S NAME & SIGNATURE:

DATES OF EMPLOYMENT (DD/MM/YY) FROM: TO:

TOTAL HOURS WORKED THIS YEAR: LICENSED AS:

TRAINER'S NAME & SIGNATURE:

DATES OF EMPLOYMENT (DD/MM/YY) FROM: TO:

TOTAL HOURS WORKED THIS YEAR: LICENSED AS:

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BENEFICIARY INFORMATION

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

RELATIONSHIP TO YOU:

STREET ADDRESS: **APT #:**

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 changed recently.

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 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***