



PENSION ANNUAL RECORD OF EMPLOYMENT

Registration #: 1049550

PLAN HOLDER'S INFORMATION

FIRST NAME: _____ LAST NAME: _____

SOCIAL INSURANCE NUMBER: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ AGCO LICENSE #: _____

EMAIL ADDRESS: _____

WORK HISTORY FOR YEAR ENDING DECEMBER 31, 2025

TRAINER NAME & SIGNATURE: _____

START DATE OF EMPLOYMENT: _____ END DATE: _____

TOTAL HOURS WORKED: _____ LICENSED AS: _____

TRAINER NAME & SIGNATURE: _____

START DATE OF EMPLOYMENT: _____ END DATE: _____

TOTAL HOURS WORKED: _____ LICENSED AS: _____

TRAINER NAME & SIGNATURE: _____

START DATE OF EMPLOYMENT: _____ END DATE: _____

TOTAL HOURS WORKED: _____ LICENSED AS: _____

TRAINER NAME & SIGNATURE: _____

START DATE OF EMPLOYMENT: _____ END DATE: _____

TOTAL HOURS WORKED: _____ LICENSED AS: _____

APPLICANT NAME AND SIGNATURE: _____ DATE: _____



PENSION ANNUAL RECORD OF EMPLOYMENT

Registration #: 1049550

BENEFICIARY INFORMATION

FIRST NAME: _____

LAST NAME: _____

RELATIONSHIP TO YOU: _____

MAILING ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____

EMAIL ADDRESS: _____

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 has 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

APPLICANT SIGNATURE & DATE: _____ WITNESS SIGNATURE: _____