

ASSOCIATED EYE CARE
401(k) PLAN
PARTICIPANT ELECTION FORM

PARTICIPANT DATA:

Participant's Name (Please Print)

Social Security Number

Address

PAYROLL REDUCTION ELECTION:

Payroll Reduction Percentages
(Circle One)

I hereby direct the Company, under the terms of the Plan, to reduce my pay by the percent I have indicated as my "Salary Deferral Contributions" and contribute this amount to the plan.

1%	2%	3%	4%	5%
6%	7%	8%	9%	10%
11%	12%	13%	14%	15%
16%	17%	18%	19%	20%
21%	22%	23%	24%	25%

OR

_____ other%

\$_____ per pay period

I do not wish to have my pay reduced.

AUTHORIZATION:

Upon signing, I understand that I am giving authorization for the information on this form to take effect according to the terms of the Plan Document and/or Plan administrative procedures and to continue in effect until future changes are made in writing as provided by the Plan.

Employee Signature

Date

Plan Administrator Signature

Date