MAIL CHECK AUTHORIZATION FORM

This is to certify that I give ***SAFEWAY HEALTHCARE SERVICES INC.*** to mail my check to the address provided on my application. I do understand that ***SAFEWAY HEALTHCARE SERVICES INC.,*** is not for any delay/lost after my check has been mailed, and that another check cannot be reissued until the next pay day. If I request to have another check re-printed before then, **I understand that there will be a $15 processing fee deducted from my next check.**

I hereby give permission to have my check mailed.

Employee Name:_____ Date:_____

Employee Signature:_____ Date:_____

Pay periods are the 1st-15th with payday being on the 25th and the 16th -31st with payday on the 10th.