STRAUMANN GUARANTEE
1. **Guarantee beneficiary and scope**

This guarantee (the “Straumann Guarantee” as defined below) from the Institut Straumann AG, Basel, Switzerland (“Straumann”) applies to the products listed below and in favor of the attending physician/dentist only (the “User”). Third parties, particularly patients or intermediate suppliers, may not derive any rights from this Straumann Guarantee. The Straumann Guarantee covers the replacement of products of the Straumann® Dental Implant System SDIS and certain limited Straumann® CARES® products (the “Straumann Products”) as defined in Section 2. The Straumann Guarantee only covers the replacement of Straumann Products and not any associated costs, including but not limited to any associated treatments.

2. **Straumann Products covered by the Straumann Guarantee**

<table>
<thead>
<tr>
<th></th>
<th>Implant</th>
<th>Abutment attached to an implant*</th>
<th>Tooth- and implant-supported restoration**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5-year guarantee period</strong></td>
<td></td>
<td>Replacement with equivalent ceramic abutment*</td>
<td>Replacement with equivalent ceramic restoration**</td>
</tr>
<tr>
<td><strong>10-year guarantee period</strong></td>
<td></td>
<td>Replacement with equivalent metal abutment*</td>
<td>Replacement with equivalent metal restoration and resin nano ceramic restoration**</td>
</tr>
<tr>
<td><strong>Lifetime guarantee period</strong></td>
<td>Replacement with equivalent implant and equivalent abutment, if necessary</td>
<td>Replacement with equivalent ceramic abutment*</td>
<td>Replacement with equivalent ceramic restoration**</td>
</tr>
</tbody>
</table>

* including screw-retained bars and bridges; excluding consumable products and retentive products such as ball anchors.

** including Straumann® CARES® copings, full contour crowns and bridges. EXCLUDING all other products offered by Straumann, particularly Straumann® CARES®, inlays, onlays, veneers, partial crowns and Straumann® CARES® Guided Surgery products.

3. **Guarantee conditions**

Straumann hereby guarantees that, if any Straumann Product is defective as a result of a failure of the material strength and stability of the Straumann Product during the guarantee periods set out in Section 2, Straumann will replace the Straumann Product with the same or substantially equivalent product as set forth in Section 2. The guarantee periods above commence at the time of treatment with a Straumann Product by the User. Provided however that the following guarantee conditions are individually and collectively met and documented:
3.1 Straumann Products have been used exclusively and not in combination with any other manufacturer’s products;

3.2 Return of the Straumann Products in sterilized condition, disinfected if appropriate or as indicated in the instructions for use;

3.3 Compliance with and application of Straumann’s instructions (in the instructions for use, among others) valid at the time of treatment as well as recognized dental procedures, during and after the treatment;

3.4 Good oral hygiene of the patient as monitored by the User;

3.5 No guarantee case resulting from an accident, a trauma or any other damage caused by the patient or a third party;

3.6 Filing of a completed and signed guarantee form not later than three months after a guarantee case arises;

3.7 For customized Straumann Products the User shall provide Straumann with the design data.

4. Limits and limitations

This Straumann Guarantee is the only guarantee provided by Straumann and shall apply in addition to the warranty rights conferred under the sales agreement. The User remains free to claim rights against his supplier. STRAUMANN HEREBY DISCLAIMS ANY OTHER WARRANTIES, EXPRESS OR IMPLIED AND STRAUMANN HEREBY EXCLUDES ANY LIABILITY FOR LOST EARNINGS AND DIRECT OR INDIRECT DAMAGES AS WELL AS COLLATERAL AND CONSEQUENTIAL DAMAGES, DIRECTLY OR INDIRECTLY RELATED TO STRAUMANN PRODUCTS, SERVICES OR INFORMATION.

5. Guarantee territory

This Straumann Guarantee applies worldwide to Straumann Products sold by a Straumann affiliated company or an official distributor of Straumann.

5. Modification or termination

Straumann may modify or terminate this Straumann Guarantee at any time in whole or in part. Changes to or the termination of the Straumann Guarantee will not affect the guarantee given under this Straumann Guarantee for Straumann Products installed prior to the date of the change or termination.
## GUARANTEE QUESTIONNAIRE

### 1. CUSTOMER INFORMATION

<table>
<thead>
<tr>
<th>Clinician’s Name</th>
<th>Customer Account #</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
<th>Country</th>
<th>Reported by</th>
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### 2. PRODUCT INFORMATION [Please list all involved Straumann Products]

<table>
<thead>
<tr>
<th>Article Number</th>
<th>LOT Number</th>
<th>Placement Date (D/M/Y)</th>
<th>Removal Date (D/M/Y)</th>
<th>Region</th>
</tr>
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</table>

### 3. GENERAL PATIENT INFORMATION [Complete this section only if returning implants]

<table>
<thead>
<tr>
<th>Patient ID No</th>
<th>Age</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

**Medical Record:**
- Diabetes Mellitus
- Radiation Tumor/neck area
- Illness requiring steroids
- Chemotherapy around time of implant placement
- Allergies: __________________
- Other local or systemic diseases which may be significant: __________________
- Does the patient smoke? Yes ☐ No ☐
- No significant findings

### 4. SURGICAL INFORMATION [Complete this section only if returning implants]

- Manual placement ☐ Handpiece adapter ☐
- If implant was placed and removed the same day, was another implant successfully placed in the site during surgery? Yes ☐ No ☐
- If you experienced difficulty with inserting device/pre-mounted transfer part this occurred upon: Implant insertion into bone ☐ Removal of implant from vial ☐
- At the time of surgery, were any of the following present: Periodontal disease ☐ Local infection/subacute chronic osteitis ☐
- Bone quality:
  - Type I ☐ Type II ☐
  - Was the site tapped? Yes ☐ No ☐
  - Holding key used Yes ☐ No ☐
  - Was primary stability achieved? Yes ☐ No ☐
  - Did implant achieve osseointegration? Yes ☐ No ☐
  - Was the implant surface completely covered with bone? Yes ☐ No ☐
- Was augmentation performed at the time of surgery? No ☐ Sinus ☐ Ridge ☐
- Was GTR membrane used? No ☐ Yes ☐
- Material used: __________________
- Disease of mucous membrane ☐ Complication in site preparation ☐
- Bone quality:
  - Type III ☐ Type IV ☐
  - N/A ☐
- Other: __________________

Material used: __________________
Material used: __________________
5. EVENT INFORMATION (Complete this section only if returning implants)

Hygiene around implant □ Excellent □ Good □ Fair □ Poor

Were any of the following involved in the event?

□ Trauma/Accident □ Implant fracture □ Inadequate bone quality/quantity
□ Biomechanical overload □ Overheating of bone □ Previous bone augmentation
□ Immediate extraction site □ Peri-implantitis □ Nerve encroachment
□ Adjacent to endodontic tooth □ Infection □ Sinus perforation
□ Tongue (pressure) □ Bruxism □ Bone resorption

Other: __________________

At the time of implant failure, there was (check all that apply):

□ Pain □ Bleeding □ Swelling □ Numbness
□ Mobility □ Fistula □ Asymptomatic □ Inflammation
□ Hypersensitivity □ Increased sensitivity □ Abscess □ Other: __________________

Was the prosthesis fitted? □ No □ Yes If yes, please complete section 6.

Please comment on why you think the implant failed/ was removed:

__________________________________________________________

6. PROSTHESIS INFORMATION (Complete this section only if returning abutments and restorations)

Project no.: ____________________________

Type of restoration? □ Crown □ Model □ Insertion □ In use
□ Full (upper) □ Bridge □ RPD (upper) □ RPD (lower)
□ Full (lower) □ Other: ______________________

Date abutment was installed: ____________________________

Torque control device used? □ Yes □ No □ Unknown

Date of abutment removal (D/M/Y): ____________________________

Torque applied: □ Ncm □ Other: ______________________

Date of temporary restoration installation: ____________________________

Was the recall appointment schedule followed? □ Yes □ No

Date of final restoration installation: ____________________________

Description of event:

__________________________________________________________

7. INSTRUMENTS (Complete this section only if returning instruments)

Approximate number of uses:

□ initial use □ 2-5 □ 6-10 □ 10-15 □ more than 15

Type of cleaning method used:

□ Manual □ Ultrasonic □ Thermodisinfection □ Other: ______________________

Type of sterilization method used:

□ Autoclave □ Dry heat □ Chemiclave □ Other: ______________________

Short description of incident:

__________________________________________________________

Please return questionnaire, autoclaved product and include X-rays (as appropriate).

Use a padded pouch to return items – failure to do so could result in items lost during shipment and void guarantee program.

Autoclave all products and label them as sterile.

Based on the Straumann Guarantee Terms and Conditions, please consider replacing the above listed products.

Doctor’s Signature: ____________________________ Date: ____________________________

FOR INTERNAL USE ONLY

□ CSN □ PSO □ ASR □ RPC □ Info incomplete □ Std/No