

STRAUMANN® GUARANTEE

Dental Implant System



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.

For Straumann® Roxolid® Implants and the Straumann® PURE Ceramic Implant System, the extended „Lifetime Plus Guarantee“ applies. It covers the replacement of the Straumann® Roxolid®/PURE Ceramic Implant System product and an additional treatment compensation in the amount of _____ in case of an implant fracture with a Straumann® Roxolid® Implant/PURE Ceramic Implant System.

2. STRAUMANN PRODUCTS COVERED BY THE STRAUMANN GUARANTEE



Implant	Abutment attached to an implant	Tooth- and implant-supported restoration*
–	Replacement with equivalent ceramic abutment including ceramic screw-retained bars and bridges*	Replacement with equivalent ceramic restoration**
–	Novaloc® Abutments, replaced with equivalent Novaloc® Abutment*** Replacement with equivalent metal screw-retained bars and bridges*	Replacement with equivalent metal restoration**
Replacement with equivalent implant and equivalent abutment, if finalized.	Replacement with equivalent metal abutment	–
Replacement with equivalent implant and equivalent abutment, if necessary. Additionally, for Straumann® PURE Ceramic Implant System & Roxolid® Implants**** it covers a treatment compensation in the amount of _____ if implant fractures.	–	–

* Excluding consumable products and retentive products such as ball anchors.

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

*** Excluding any matrices and inserts as they are subject to natural wear and tear.

**** Not applicable for Straumann® Mini Implants. Straumann® Mini Implants underly the Straumann® Lifetime Guarantee.

GUARANTEE QUESTIONNAIRE

1. CUSTOMER INFORMATION

Clinician's Name

Address

Customer Account #

Telephone

Country

Reported by

2. PRODUCT INFORMATION (Please list all involved Straumann Products)

Lifetime Plus claims must be accompanied by the restoration and restoration details (include here).

Article Number	LOT Number	Placement Date (D/M/Y)	Removal/Event Date (D/M/Y)	Regio
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. GENERAL PATIENT INFORMATION (Only required with implant complaints)

Patient ID No* Age ☐ Female ☐ Male

*For data privacy reasons DO NOT insert patient's name

Medical Record:

<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Psychological disorder	<input type="checkbox"/> Uncontrolled endocrine illness
<input type="checkbox"/> Radiation Tx-head/neck area	<input type="checkbox"/> Xerostomia	<input type="checkbox"/> Compromised immuno resistance
<input type="checkbox"/> Illness requiring steroids	<input type="checkbox"/> Lymphatic disorder	<input type="checkbox"/> Blood coagulation disorder
<input type="checkbox"/> Chemotherapy around time of implant placement	<input type="checkbox"/> Drug or alcohol abuse	

Allergies:

Other local or systemic diseases which may be significant:

Does the patient smoke? ☐ Yes ☐ No ☐ No significant findings

4. SURGICAL INFORMATION (Only required with implant complaints)

☐ 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 device from implant

☐ Removal of implant from vial Other:

At the time of surgery, were any of the following present:

<input type="checkbox"/> Periodontal disease	<input type="checkbox"/> Diseased mucous membrane
<input type="checkbox"/> Local infection/subacute chronic osteitis	<input type="checkbox"/> Complication in site preparation
Bone quality <input type="checkbox"/> Type I	<input type="checkbox"/> Type II <input type="checkbox"/> Type III <input type="checkbox"/> Type IV
Was the site tapped? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Bone Level Profile Drill used? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Tissue Level Profile Drill used? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Holding Key used <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Was primary stability achieved? <input type="checkbox"/> Yes	<input type="checkbox"/> No
Did implant achieve osseointegration? <input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the implant surface completely covered with bone? <input type="checkbox"/> Yes	<input type="checkbox"/> No

Was augmentation performed at the time of surgery?

☐ No ☐ Sinus ☐ Ridge

Material used:

Was GTR membrane used?

☐ No ☐ Yes ☐ Resorbable

☐ Non-resorbable

Material used:

GUARANTEE QUESTIONNAIRE

5. EVENT INFORMATION (Only required with implant complaints)

Hygiene around implant ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Were any of the following involved in the event?

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

Other: _____

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

- | | | | |
|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Swelling | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Fistula | <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Hypersensitivity | <input type="checkbox"/> Increased sensitivity | <input type="checkbox"/> Abscess | Other: _____ |

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

If the implant is not being removed, is there evidence of the following (check all that apply)?

Extent (mm): Bone Loss _____ Dehiscence _____ Peri-implantitis _____ Fenestration _____ Other _____

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

6. PROSTHESIS INFORMATION (Only required for abutment and restoration complaints)

Project no.: _____ ☐ Model ☐ Insertion ☐ In use

Type of restoration? ☐ Crown ☐ Bridge ☐ RPD (upper) ☐ RPD (lower)

☐ Full (upper) ☐ Full (lower) Other: _____

Date of temporary restoration installation Date of final restoration installation

Date of abutment removal (D/M/Y)

Torque Control Device used? ☐ Yes ☐ No ☐ Unknown Was the recall appointment schedule followed ☐ Yes ☐ No

Torque applied Ncm

Description of event:

7. INSTRUMENTS (Only required for instrument complaints)

Approximate number of uses: ☐ initial use ☐ 2–5 ☐ 6–10 ☐ 10–15 ☐ more than 15

(Cutting instruments only)

Type of cleaning method used ☐ Manual ☐ Ultrasonic ☐ Thermoinfection Other: _____

Type of sterilization method used ☐ Autoclave ☐ Dry heat ☐ Chemiclave

Short description of incident:

Please return questionnaire, autoclaved product and include X-rays (as appropriate). **Use a padded package 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.

Please note that your data will be transferred to Institut Straumann AG, Basel, Switzerland but may also be transferred for further investigations to the countries where the respective manufacturer of the product is domiciled. This may include countries outside the European Union for which there is no European Commission decision that they ensure an adequate level of protection for personal data.

Doctor's Signature: _____ Date: _____

For internal use only

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

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