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>5-year guarantee period</td>
<td>–</td>
<td>Replacement with equivalent ceramic abutment**</td>
<td>Replacement with equivalent ceramic restoration***</td>
</tr>
<tr>
<td>10-year guarantee period</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>Lifetime guarantee period</td>
<td>Replacement with equivalent implant and equivalent abutment, if finalized.</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

* Valid as of January 1, 2016
** 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.

6. 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.
1. CUSTOMER INFORMATION

<table>
<thead>
<tr>
<th>Clinician’s Name</th>
<th>Customer Account #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
<th>Country</th>
<th>Reported by</th>
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</thead>
<tbody>
<tr>
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</table>

2. PRODUCT INFORMATION

(Please list all involved Straumann Products)

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

<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>Regio</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

3. GENERAL PATIENT INFORMATION

(Only required with implant complaints)

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

Medical Record:

- Diabetes Mellitus
- Psychological disorder
- Uncontrolled endocrine illness
- Radiation Tx-head/neck area
- Xerostomia
- Compromised immuno resistance
- Illness requiring steroids
- Lymphatic disorder
- Blood coagulation disorder
- Chemotherapy around time of implant placement
- 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:

- Periodontal disease
- Local infection/subacute chronic osteitis

Bone quality

- Type I
- Type II
- Type III
- Type IV

- Was the site tapped?  
  - Yes
  - No
  - N/A

- Bone level profile drill used?  
  - Yes
  - No
  - N/A

- Tissue level profile drill used?  
  - Yes
  - No
  - N/A

- Holding key used  
  - Yes
  - No
  - N/A

- Was primary stability achieved?  
  - Yes
  - No
  - N/A

- Did implant achieve osseointegration?  
  - Yes
  - No
  - N/A

- Was the implant surface completely covered with bone?  
  - Yes
  - No
  - N/A

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?

□ 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.

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.: __________________________

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

Date abutment was installed __________________________

Date of abutment removal (D/M/Y) __________________________

Torque control device used? □ Yes □ No □ Unknown

Torque applied □ Ncm

Date of temporary restoration installation __________________________

Date of final restoration installation __________________________

Was the recall appointment schedule followed □ Yes □ No

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 □ Thermodisinfection □ 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 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