



# 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

	Implant	Abutment attached to an implant*	Tooth- and implant-supported restoration**
5-year guarantee period	–	Replacement with equivalent ceramic abutment**	Replacement with equivalent ceramic restoration***
10-year guarantee period	–	Replacement with equivalent metal abutment**	Replacement with equivalent metal restoration and resin nano ceramic restoration***
Lifetime guarantee period	Replacement with equivalent implant and equivalent abutment, if finalized.	–	–

\* 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.

# Guarantee Questionnaire

## 1. CUSTOMER INFORMATION

Clinician's Name	<input type="text"/>	Customer Account #	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Country	<input type="text"/>
	<input type="text"/>	Reported by	<input type="text"/>

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

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

Article Number	LOT Number	Placement Date (D/M/Y)	Removal 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

### 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:

<input type="checkbox"/> Implant insertion into bone	<input type="checkbox"/> Removal of device from implant
<input type="checkbox"/> 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:

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## 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 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:

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## 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:

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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

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