



**THE STRAUMANN GUARANTEE**  
WE CARE!



COMMITTED TO  
**SIMPLY DOING MORE**  
FOR DENTAL PROFESSIONALS

WE INSPIRE YOUR **CONFIDENCE.**



## THE STRAUMANN GUARANTEE – WE CARE!

Interdisciplinary research and cooperation are crucial for success and customer satisfaction in implant dentistry.

Working in close collaboration with the International Team for Implantology (ITI) the Institut Straumann AG develops, manufactures and markets the Straumann® Dental Implant System, today's No. 2 worldwide. The Straumann® Dental Implant System is currently one of the best documented systems in implant dentistry with more than 2000 scientific publications.

As a Swiss company, our priority has always been the production of our Straumann products to the highest quality. This commitment now means even more advantages for our users.

The Straumann® Dental Implant System has a sound scientific and clinical basis, and benefits from expertise gained from almost 30 years of quality production.

In addition the Straumann Guarantee covers the replacement of all components of the Straumann® Dental Implant System for the user.

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## OVERVIEW

### The Straumann Guarantee

For detailed information on terms and conditions, please refer to the following pages.

#### Following Conditions must be fulfilled:

- indications/contraindications observed
- procedure performed in accordance with generally accepted dental practice
- Straumann instructions per package inserts/manuals followed
- oral hygiene maintained
- recall interval maintained
- no adverse health conditions during life-span of implant (anamnesis), that could impact implant success, e.g. as detailed in the package insert
- registration form must be completed and signed
- product must be returned sterilized within 90 days of incident for identification purposes
- no overdue payments owed to Straumann
- only original Straumann products used

	Implants in general	Implants Ø 3,3 mm	Implants Hollow Body	Abutments/ Instruments
Implant unloaded	Replacement of the equivalent implant			not applicable
Implant loaded	Replacement of the equivalent implant & restorative parts, if not older than 10 years from date of loading.			not applicable
Wear and Tear	not applicable			<b>Replacement of equivalent product</b> if within 10 years of loading or purchase except for those products with a defined lifetime.

# STRAUMANN GUARANTEE – CONDITIONS

## **The guarantee applies to the Straumann® Dental Implant System, further referred to as “Straumann products and components”.**

### **1. Scope of the guarantee**

As part of the guarantee program, Straumann guarantees the treatment provider who has fitted his patients with original Straumann implants after 1.1.1997 in accordance with the following terms and conditions to replace these implants. The guarantee covers only normal wear of components within the ten year guarantee period or occurring during the guarantee period indicated in the enclosed leaflet or product information. The guarantee is subject to the condition that the patient does not exhibit the contraindications detailed in the product description either before or during the entire period of implantation.

This obligation only applies to Straumann products which have been sold and are used in the countries listed in the following. The basis of the guarantee is always the individual guarantee certificate received on delivery of a Straumann product. This obligation exists only with respect to a treatment provider (doctor/dentist). Third parties, in particular patients or intermediate suppliers, may not derive any rights from the guarantee. The assignment of claims arising from the guarantee statement is excluded.

This guarantee program does not give entitlement to a guarantee certificate for a specific product.

The guarantee program is valid in the following countries:

Australia, Austria, Belgium, Brazil, Canada, Denmark, Finland, France, Germany, Italy, Mexico, the Netherlands, Norway, Spain, Sweden, Switzerland, UK, USA.

### **2. Guarantee conditions and exclusions**

Optimum care of the patient and care by the patient are necessary conditions for successful implantation. Straumann only undertakes to provide a replacement, if the attachment fails within the ten year period despite the treatment provider and/or the patient having satisfied the followed fundamental conditions:

- 2.1 The patient must be carefully selected, informed of inherent risks and patient duties associated with the treatment, and encouraged to co-operate by the treatment provider;
- 2.2 Indications/contra-indications must be carefully observed and documented;
- 2.3 Straumann instructions as available at the time of treatment and accepted dental practice must be observed and applied accordingly before, during and after implantation;
- 2.4 Constant and good oral hygiene by the patient, confirmed in check-ups, and recall intervals must be ensured and documented;
- 2.5 The product which is the subject of complaint must be returned in sterilized form for identification purposes. A completed guarantee form, the original guarantee certificate and additional documentation as required to fulfill guarantee conditions must be returned with the product;
- 2.6 The guarantee is invalidated if:
  - Straumann products have not been applied in accordance with Straumann instructions, or have been modified, or if Straumann products have been used in conjunction with non-Straumann products;
  - contra-indications for the treatment with implants and components, contained in a Straumann or ITI product or application description, exist;
  - the products are custom-made or specially manufactured or modified;
  - failure of an implant is brought about by an accident, a trauma or by any other damage caused by the patient or a third party.

3. **Guarantee procedure**

If you consider yourself eligible for the guarantee program, the guarantee procedure requires that a completed and signed guarantee form (including the attachments specified therein) together with the original guarantee certificate is submitted to Straumann not later than three months after the failure of the implant and/or components. All components returned must be sterilised.

4. **General limitations of the guarantee**

The guarantee specified in this document is the only Straumann guarantee. This guarantee is valid independently alongside the guarantee rights resulting from the Contract of Supply. The customer is at liberty to enforce his rights in respect of his supplier or the rights resulting from this guarantee. Straumann (including affiliates) or distributors of Straumann do not make any guarantee or assurance, expressed or implied, written or oral, with respect to Straumann components, including (but not limited to) any implied guarantee of merchantability, durability or fitness for a particular use or purpose.

This guarantee does not cover consequential damage of any kind and Straumann (including affiliates) disclaims all liability to a treatment provider for loss of business, earnings, income or profits. Straumann also disclaims any and all liability with respect to failure of a treatment provider to conform or not to conform to generally accepted dental practice, and all other direct or indirect damage, incidental or consequential, directly or indirectly relating to Straumann products, services or information.

5. **Termination**

Straumann may modify or terminate this guarantee program at any time with respect to any product or service or with respect to the eligibility of a specific treatment provider.

6. **Miscellaneous**

By taking part in this guarantee program and purchasing products from Straumann in connection therewith, the treatment provider accepts the terms and conditions provided for herein.

7. **Other territories**

Other conditions may apply for markets not covered by the countries specified in Art. 1. Please contact Straumann or your nearest Straumann representative for information.

# Guarantee Form

## 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"/>

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

Article Number	LOT Number	Placement Date (D/M/Y)	Removal Date (D/M/Y)	Site of implant
<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"/>
<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"/>

## GENERAL PATIENT INFORMATION

Patient ID  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 immunoresistance
<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 more than one pack/day?  Yes  No

No significant findings

## IMPLANT FAILURE – Surgical Information (Complete this section 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:**

<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
Holdingkey 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?**

<input type="checkbox"/> No	<input type="checkbox"/> Sinus	<input type="checkbox"/> Ridge	Material used: _____
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**Was GTR membrane used?**

<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Resorbable	<input type="checkbox"/> Non-resorbable Material used: _____
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**EVENT INFORMATION (Complete this section if returning implants)**

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                |
| Other: _____  | <input type="checkbox"/> Tongue              | <input type="checkbox"/> Bruxism                          |

**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 | Other: _____                      |

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

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

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**PROSTHESIS INFORMATION**

Type of prosthesis?  Crown  Bridge  RPD (upper)  RPD (lower)  
 Full (upper)  Full (lower)  Telescope

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 prosthesis installation

Date of final prosthesis installation

Was the recall appointment schedule followed  Yes  No

**Comments:**

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**INSTRUMENTS (Complete this section if returning instruments)**

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  Thermodesinfection Other: \_\_\_\_\_

Type of sterilization method used  Autoclave  Dry heat  Chemiclave

Short description of incident:

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Please return registration form, 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.

Doctors Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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