



STRAUMANN GUARANTEE

WE CARE!



STRAUMANN GUARANTEE®

COMMITTED TO
SIMPLY DOING MORE
FOR DENTAL PROFESSIONALSSM

STRAUMANN GUARANTEE

1. Guarantee beneficiary and scope

This guarantee (the "Straumann Guarantee" as defined below) from the Institut Straumann Ltd, 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
Lifetime guarantee period	Replacement with equivalent implant and equivalent abutment, if necessary	–	–

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

** Including Straumann® CARES® copings, crowns and bridges. Excluding all other products offered by Straumann, particularly Straumann® CARES® inlays, onlays and veneers as well as 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 placement 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;
- 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.

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 only applies to Straumann Products sold by a Straumann affiliated company and sold in one of the following countries (the "Guarantee Territory"): Australia, Austria, Belgium, Brazil, Canada, Czech Republic, Denmark, Finland, France, Germany, Hungary, Italy, Ireland, Japan, Luxembourg, Liechtenstein, Mexico, the Netherlands, Norway, New Zealand, Portugal, Spain, Sweden, Switzerland, Slovakia, South Korea, the UK and the USA.

GUARANTEE FORM

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)

Article Number	LOT Number	Placement Date (D/M/Y)	Removal Date (D/M/Y)	Region
<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 (Complete this section only if returning implants)

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 (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:

<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
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: _____

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?

- | | | |
|---|--|---|
| <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.

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 Bridge Full (upper) Full (lower) Model Insertion In use RPD (upper) RPD (lower) Other: _____

Date abutment was installed Date of abutment removal (D/M/Y)

Torque control device used? Yes No Unknown

Date of temporary restoration installation Torque applied Ncm

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

(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

www.straumann.com



STRAUMANN GUARANTEE

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