straumann®

# STRAUMANN GUARANTEE

## WE CARE!

STRAUMANN GUARANTEE®

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

# 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

Address

Customer Account #

Telephone

Country

Reported by

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

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

## 3. GENERAL PATIENT INFORMATION (Complete this section only if returning implants)

Patient ID No

Age

☐ Female ☐ Male

**Medical Record:**

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

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:**

- ☐ Implant insertion into bone
- ☐ Removal of implant from vial
- ☐ Removal of device from implant
- Other: _____

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

- ☐ Periodontal disease
- ☐ Local infection/subacute chronic osteitis
- ☐ Diseased mucous membrane
- ☐ Complication in site preparation

| | | | | |
|---|---|---|---|---|
| Bone quality | ☐ Type I | ☐ Type II | ☐ Type III | ☐ Type IV |
| Was the site tapped? | ☐ Yes | ☐ No | ☐ N/A | |
| Holding key used | ☐ Yes | ☐ No | ☐ N/A | |
| Was primary stability achieved? | ☐ Yes | ☐ No | | |
| Did implant achieve osseointegration? | ☐ Yes | ☐ No | | |
| Was the implant surface completely covered with bone? | ☐ Yes | ☐ 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?**

☐ Trauma/Accident
☐ Biomechanical overload
☐ Immediate extraction site
☐ Adjacent to endodontic tooth
☐ Tongue (pressure)
☐ Implant fracture
☐ Overheating of bone
☐ Peri-implantitis
☐ Infection
☐ Bruxism
☐ Inadequate bone quality/quantity
☐ Previous bone augmentation
☐ Nerve encroachment
☐ Sinus perforation
☐ 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.

**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.: _____ ☐ 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:**

_____

_____

_____

## 7. INSTRUMENTS (Complete this section only if returning instruments)

Approximate number of uses: (Cutting instruments only) ☐ initial use ☐ 2–5 ☐ 6–10 ☐ 10–15 ☐ more than 15

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

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