

Orthodontist Check List

The following items must be submitted to CDN in order to process your application.

- Orthodontist Agreement signed by CONTRACTING dentist—no delegated signatures allowed (enclosed).
- Individual Dentist Information for CONTRACTING dentist and signed by CONTRACTING dentist only (enclosed).
- Dental Facility Information (enclosed)
- W-9 Request for Taxpayer Identification Number and Certification (enclosed)

For the Contracting Orthodontist only:

- Copy of current Dental License
- Copy of current DEA Certificate
- Copy of current CPR Certificate
- Copy of current Malpractice Insurance Declaration Page
- Certificate of Orthodontic Specialty

California Dental Network, Inc.

1971 E. 4th Street, Suite 184
Santa Ana, CA 92705-3917

Phone (714) 479-0777: Toll-Free (877) 4-DENTAL: Fax (714) 479-0779

Dental Services Agreement **For Orthodontists**

This Agreement is made and entered into this ____ day of _____, 20__ by and between California Dental Network, Inc., a California corporation, (hereinafter referred to as "CDN"), and _____ (hereinafter referred to as "ORTHODONTIST").

In consideration of the mutual covenants hereinafter contained, the parties hereby agree:

Declarations

CDN is a Health Care Service Plan licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 to provide or arrange for dental care to members enrolled under Individual or Group Subscriber Agreements.

ORTHODONTIST operates and maintains an orthodontic practice in the State of California and wishes to treat CDN members as patients in his/her practice under the terms and conditions of such member's enrollment in CDN.

I. MEMBERS ELIGIBLE FOR SERVICES.

Members eligible for treatment by ORTHODONTIST under this Agreement shall be only those members covered under a Group or Individual Subscriber Agreement with CDN at the time orthodontic services are rendered. Before rendering or refusing services to any person claiming to be a CDN member, ORTHODONTIST shall telephone CDN for verification of the person's eligibility status and obtain an authorization, if applicable. ORTHODONTIST must obtain a written authorization from CDN for the treatment of any member where all or any portion of the payment for orthodontic services is made by CDN. CDN's authorization shall be in writing and shall set forth the benefits to which the member is entitled, the amount of member copayments, and the amount and timing of payments that will be made by CDN.

II. RENDERING CARE TO ELIGIBLE MEMBERS.

ORTHODONTIST shall render all covered orthodontic services to each member eligible for service under this Agreement during ORTHODONTIST's regular office hours, and subject to ORTHODONTIST's usual appointment scheduling practices. Covered services shall be provided in accordance with the Principle Benefits, Principle Exclusions and Principle Limitations contained in the Group or Individual Subscriber Agreement under which the member is enrolled. ORTHODONTIST shall have the right, within the framework of professional ethics, to reject any patient seeking ORTHODONTIST's professional services.

ORTHODONTIST shall provide appointments to eligible members upon reasonable request, which shall not exceed two weeks for non-emergency cases. ORTHODONTIST shall also provide 24-hour emergency services and will arrange for coverage of emergencies during vacations and other periods when ORTHODONTIST's office is closed, or make other arrangements for services.

III. SERVICES NOT COVERED AND OTHER FEES DUE DIRECTLY FROM MEMBER.

It is expressly agreed that ORTHODONTIST shall look solely to the member, or the member's responsible party, for payment of orthodontic services which are not covered by CDN and for the payment of copayments that are to be paid by the member for certain covered services. CDN shall have no responsibility for the payment of non-covered services or for the patient's copayments for covered services. ORTHODONTIST shall bill the member for non-covered services at a rate not to exceed the ORTHODONTIST's usual and customary fees.

IV. PAYMENT TO ORTHODONTIST FOR SERVICES UNDER THIS AGREEMENT.

ORTHODONTIST agrees to accept, as payment in full for all covered services provided to CDN members, the amounts set forth in Attachment A, which are inclusive of member copayments, where applicable.

ORTHODONTIST shall look solely to CDN for payment of amounts due from CDN under this Agreement, and members shall not be directly or indirectly liable for amounts due from CDN during the term of this Agreement and/or after termination. ORTHODONTIST acknowledges that Section 1379 of the Knox-Keene Health Care Service Plan Act prohibits providers, and agents or trustees thereof, from bringing any action at law against a member to collect amounts owed from a Health Care Service Plan.

ORTHODONTIST agrees that CDN has the right to deduct, offset or withhold from any payment(s) otherwise due ORTHODONTIST, amounts due from ORTHODONTIST through ORTHODONTIST's neglect or failure to fulfill any business or patient obligation that involves CDN's members, operations and/or obligations.

V. TREATMENT BY ANOTHER DENTIST OR SPECIALIST.

If, in ORTHODONTIST's professional opinion, a member requires the services of a general dentist or specialist, ORTHODONTIST shall refer the member, along with all appropriate records and x-rays to the CDN general dentist that the member has selected or been assigned to provide the member's primary dental care. The member's general dentist will treat the member's condition, or obtain approval for a specialty referral. If the member's general dentist disagrees with ORTHODONTIST's opinion, ORTHODONTIST may submit the matter to CDN's Dental Director, who shall confer with ORTHODONTIST and the member's general dentist to discuss the diagnosis and the member's benefits, if applicable.

VI. DURATION AND TERMINATION OF AGREEMENT.

This Agreement shall be for a period of one year from CDN's approval date, indicated below, and shall automatically renew for additional one-year periods until terminated. Either party may terminate this Agreement, at any time, by giving a 60-day written notice to the other party by registered or certified mail. Notwithstanding this provision, CDN may terminate this Agreement, immediately upon notice to ORTHODONTIST if ORTHODONTIST materially fails to comply with this Agreement or CDN's Quality Assurance requirements, or fails to maintain adequate insurance as required under Section X of this Agreement.

VII. OBLIGATIONS AFTER NOTICE AND TERMINATION OF AGREEMENT.

In the event notice of termination is given, by either party, ORTHODONTIST shall continue to render authorized services and treat members in accordance with this Agreement, as if notice was not given, until the date this Agreement terminates. ORTHODONTIST shall, at the time a member seeks an appointment and again prior to rendering orthodontic services, notify each member that he/she has given notice of termination with the effective date, or is no longer a participating CDN provider, whichever the case may be at such time. ORTHODONTIST shall not render any covered orthodontic services to CDN members after the date this Agreement terminates, except that ORTHODONTIST shall complete all cases started prior to the termination date in accordance with the provisions of this Agreement. ORTHODONTIST agrees to forward to the member's new orthodontist or general dentist copies of all patient records and x-rays within 30 days of a request from the member, another ORTHODONTIST or the general dentist treating the member.

Termination of this Agreement does not relieve ORTHODONTIST of the responsibilities to maintain insurance and indemnify CDN and its agents as set forth in Section X, to maintain and provide access to books and records as set forth in Section XII, or to the dispute resolution procedures set forth in Section XVI of this Agreement.

VIII. STANDARD OF ORTHODONTIST CARE.

ORTHODONTIST agrees that all services rendered to members under this Agreement shall be in accordance with the high standards of the dental profession for competence, care and concern for the welfare and needs of each member as set forth in the "Principals of Ethics of the American Dental Association" and the "Dental Practice Act" of the State of California. ORTHODONTIST will not discriminate in the treatment of member patients and agrees to provide services to members equal in all respects to that provided to non-member patients of his/her practice. Furthermore, ORTHODONTIST shall not discriminate against any group or member, or prospective group or member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age.

IX. ORTHODONTIST-PATIENT RELATIONSHIP.

ORTHODONTIST shall maintain the orthodontist-patient relationship with each member eligible for services under this Agreement and shall be solely responsible to such members for any dental advice and/or treatment. It is expressly agreed between the parties that ORTHODONTIST is an independent contractor and that neither the member, CDN, nor any group contracting with CDN shall control or dominate the ORTHODONTIST's practice, practice personnel, facilities or the orthodontist-patient relationship.

X. INSURANCE AND INDEMNIFICATION.

ORTHODONTIST agrees to carry, at all times during the term of this Agreement and for at least seven years thereafter, such policies of professional liability and other insurance as shall be necessary to insure ORTHODONTIST and ORTHODONTIST's employees, agents, associates or affiliates against any claim(s) for damages, personal injury or death caused directly or indirectly in connection with the provision of services, lack of services, or the uses of any property, facilities or equipment under this Agreement. ORTHODONTIST shall provide CDN with "Certificates of Insurance" from ORTHODONTIST's insurance carrier(s) to evidence the existence of such coverage(s) in amounts acceptable to CDN. Failure to maintain such insurance is grounds for CDN to immediately terminate this Agreement. CDN may provide copies of such certificate(s) to any group or potential group upon request. ORTHODONTIST hereby agrees to indemnify and hold harmless CDN and any of CDN's officers, directors, agents, representatives and/or employees from and against all claims, suits, demands, actions, losses, liabilities and expenses, (including, without limitation, actual legal fees and expenses), that may arise out of any; (1) act or omission by ORTHODONTIST or any of ORTHODONTIST's employees, agents, associates, or affiliates in connection with any orthodontic services, lack of services, or the uses of any property, facilities or equipment pursuant to this Agreement; (2) breach or failure of ORTHODONTIST or ORTHODONTIST's employees, agents, associates, or affiliates to perform any representation, warranties, covenants or term(s) of this Agreement; (3) liability of ORTHODONTIST, whether contingent, absolute, direct, indirect, matured or unmatured.

XI. PROHIBITION OF SURCHARGES.

ORTHODONTIST shall not surcharge members for covered services. A surcharge, as used herein, is an additional fee which is charged to a member for a covered service but which is not approved by the Commissioner of Corporations, or provided for in the Group or Individual Subscriber Agreement under which the member is enrolled. ORTHODONTIST must report in writing to CDN all copayments and surcharges paid by members to ORTHODONTIST, unless the Commissioner of Corporations expressly approves otherwise.

XII. RECORDS AND REPORTS.

ORTHODONTIST shall maintain such records and provide such information to CDN or the Commissioner of Corporations as may be necessary for CDN to comply with the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder. Such records shall be retained for a period of at least five years, the last two years of which shall be in an easily accessible place at ORTHODONTIST's office. CDN and/or the Commissioner of Corporations shall have access, during normal business hours and with reasonable notice to the books and records, including financial records, and documents of ORTHODONTIST relating to the orthodontic services provided to CDN members, to the cost of such services and to payments received by ORTHODONTIST from CDN members, or from others on the member's behalf.

XIII. ORTHODONTIST'S PARTICIPATION IN CDN COMMITTEES AND POLICIES.

ORTHODONTIST agrees to cooperate with, participate in and abide by CDN's policies and procedures regarding the administration of its plans, including but not limited to CDN's Quality Assurance and Peer Review Programs, Grievance Resolution Process and Public Policy Participation System.

XIV. NON-EXCLUSIVE.

DENTIST agrees to cooperate with, participate in and abide by CDN's policies and procedures regarding the administration of its plan, including but not limited to CDN's Quality Assurance and Peer Review Programs, Grievance Resolution Process, Pubic Policy Participation System, and the Plan's Language Assistance Program Standards."

XV. ASSIGNABILITY.

This Agreement is intended to secure the personal services of ORTHODONTIST, and his/her associates, and therefore may not be assigned or transferred without the written consent of CDN.

XVI. DISPUTE RESOLUTION.

The Plan maintains a provider dispute resolution process to deal with all provider complaints. Any disputes or complaints shall be made to CDN in writing or contacting CDN at the address and telephone number indicated herein. Providers will receive a written response within 30 days as to the disposition of the complaint. Appeal of the decisions regarding the provider's complaint may be made in writing to the Plan's Public Policy or Quality Assurance Committee. If the provider is not satisfied with the Public Policy or Quality Assurance Committee's decision, the provider may pursue binding arbitration in accordance with the rules of the American Arbitration Association. Arbitration shall be held in Orange County, California and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The prevailing party shall be entitled to recover its costs and reasonable attorneys' fees. In addition, ORTHODONTIST agrees to comply with any and all arbitration proceedings initiated by members involving CDN, a CDN contractor or CDN employee, agent or representative.

XVII. GOVERNING LAW.

The parties agree that the laws of the State of California shall govern the validity, construction and interpretation of this Agreement. ORTHODONTIST agrees that any amendment to this agreement or any of CDN's manuals, policies or procedures required to meet state or federal laws or regulations governing Knox-Keene Health Care Service Plans, or any accreditation requirements of a private sector accreditation organization to which CDN participates, shall automatically become part of this Agreement. In the event of any inconsistency between this agreement and such laws, regulations or accreditation requirements, the applicable laws, regulations or accreditation requirements shall prevail over any provision of this Agreement. In the event a court or arbitrator(s) with component jurisdiction determines that any provision of this Agreement is invalid, for any reason, the remaining provisions of this Agreement shall be binding upon the parties.

XVIII. ENTIRE AGREEMENT.

This Agreement along with any amendments and attachments constitutes the sole and entire contract and understanding between the parties hereto with respect to the subject matter hereto and no amendment to this agreement shall be effective unless it is in writing and signed by an authorized representative of CDN. CDN may from time to time amend this agreement by providing ORTHODONTIST with a 30 day written notice of the changes. Except as set forth in Section XVII, CDN shall not make any material change to this agreement or its manuals, policies or procedures without providing ORTHODONTIST with a notice of the changes, at least 45 business days before the effective date of the change. ORTHODONTIST has the right to negotiate and agree to the changes during the notice periods. If CDN and ORTHODONTIST cannot agree with the changes, ORTHODONTIST may terminate this agreement prior to the effective date of any change.

XIX. NOTICES.

Any notice or other communication required or permitted hereunder shall be in writing, and shall be deemed to have been given if personally delivered or 24 hours after placed in the United States mail, first class postage-paid addressed to:

ORTHODONTIST:

CDN:
Stephen R. Casey, President
California Dental Network, Inc.
1971 E. 4th St., #184
Santa Ana, CA 92705-3917

In witness whereof, the parties hereto have entered into this Agreement as of the date indicated above.

ORTHODONTIST: _____
Print Name

CALIFORNIA DENTAL NETWORK, INC.

Signature: _____

Signature: _____

Date: _____

Name/Title: Stephen R. Casey, President

SSN or Federal Tax ID #: _____

Approval Date: _____

California Dental Network, Inc.

Dental Services Agreement for Orthodontists

Attachment A

(Revised 10/06)

Schedule of Reimbursements

ORTHODONTIST agrees to accept as payment in full for all covered services provided to CDN members, the following amounts, which are inclusive of member copayments, where applicable:

	Orthodontic Plans				
	101	102	103	104	105
<u>Limited Orthodontic Treatment *</u>					
D8020 Transitional Dentition	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
D8030 Adolescent Dentition	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
D8040 Adult Dentition	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,150.00
<u>Interceptive Orthodontic Treatment *</u>					
D8050 Interceptive – Primary Dentition	\$1,000.00	\$1,000.00	\$1,150.00	\$1,150.00	\$1,250.00
D8060 Interceptive – Transitional Dentition	\$1,000.00	\$1,000.00	\$1,150.00	\$1,150.00	\$1,250.00
<u>Comprehensive Orthodontic Treatment *</u>					
D8070 Transitional Dentition	\$1,600.00	\$1,695.00	\$1,775.00	\$1,845.00	\$1,995.00
D8080 Adolescent Dentition	\$1,600.00	\$1,695.00	\$1,775.00	\$1,845.00	\$1,995.00
D8090 Adult Dentition	\$1,950.00	\$1,695.00	\$1,975.00	\$2,045.00	\$2,195.00

* - Treatment is limited to 24 months, Orthodontist may charge for each visit over 24 months, as specified below.

Other Orthodontic Services

D8660 Pre-Orthodontic Treatment Visit (Consult)	\$ 40.00	\$ 40.00	\$25.00	\$25.00	\$40.00
D8670 Periodic Orthodontic Treatment Visit (As Part of Contract)	No Charge	No Charge	No Charge	No Charge	No Charge
D8680 Orthodontic Retention - Per Arch (Includes 12 months follow up)	\$150.00	\$150.00	\$125.00	\$125.00	\$150.00
Orthodontic Appliances (head gear, maxillary expansion, etc.)	UCR	UCR	UCR	UCR	UCR
Diagnostic Records (x-rays, models, tracings, etc.)	\$250.00	\$250.00	\$250.00	\$250.00	\$300.00
Additional Visits (beyond 24-months)	\$50.00	\$50.00	\$25.00	\$25.00	\$50.00
Broken Appointments (without 24-Hour Notice)	\$40.00	\$40.00	\$40.00	\$40.00	\$40.00

Providers are not required to participate in all benefit plans!
You may choose to participate in only the benefit plans you select.

Please indicate below the orthodontic plans that your office wishes to participate in:
Please Initial Selected Orthodontic Plan(s)

_____101 _____102 _____103 _____104 _____105



**Provider Application
Individual Dentist Information**

(Must be completed for each dentist who will treat CDN Members)

Dentist:

Full Name _____
(Please Print)

Degree(s) _____

Social Security Number _____ - _____ - _____

Date of Birth _____ - _____ - _____

CA Dental License #'s _____

DEA Number _____

Education/Training:

Undergraduate School _____ Degree _____ Year Graduated _____

Post Graduate School _____ Degree _____ Year Graduated _____

Dental School _____ Degree _____ Year Graduated _____

Residency _____
Facility _____ Location _____

Specialty Field _____ Dates _____

Other Training Programs _____
Facility _____ Location _____

Specialty Field _____ Dates _____

Professional Associations:

Membership in dental societies and associations: _____

Positions of responsibility in local, state or national dental associations: _____

Dental school or other teaching appointments: _____

Scope of Practice:

(General Dentists Only)

Please check the service that you routinely perform for your patient.

- Periodontics
- ___ Scaling/Root Planning
- ___ Soft tissue management
- ___ Surgery

- Endodontics
- ___ Anterior root canals
- ___ Bicuspid root canals
- ___ First molars
- ___ Second molars
- ___ Apical surgery

- Oral Surgery
- Surgical removal of:
- ___ Erupted tooth
- ___ Soft tissue impactions
- ___ Partial bony impactions
- ___ Full bony impactions

(Over)

Liability Coverage:

Liability Carrier _____

Policy Number _____ Expiration Date _____

Amount of Coverage Per Occurrence _____ Aggregate _____

Do you have any pending malpractice cases/claims against you? Yes ___ No ___

Number of prior malpractice settlements/judgments _____

For each malpractice action, please attach an explanation, which includes the facts of each action and the amount of settlement.

Licensure:

Have you ever:

Had your license, in any state, suspended, revoked, restricted or limited? Yes ___ No ___

Been conviction, or pleaded guilty to a felony, moral or ethical crime? Yes ___ No ___

Had any chronic illnesses, physical defects or addiction, that would impair your ability to practice dentistry? Yes ___ No ___

Had your membership denied, not renewed, or been subject to disciplinary proceedings in any dental organization? Yes ___ No ___

Been licensed to practice dentistry in another state, or under another name? Yes ___ No ___

Please attach an explanation for any questions answered "Yes".

Certification & Release of information:

The undersigned hereby certifies that the above information is true, correct and complete to the best of my knowledge, and that the intentional submission of false or misleading information or withholding of relevant information is grounds for denial or termination as a participating provider with California Dental Network, Inc., or any of its affiliated organizations. The undersigned hereby authorizes California Dental Network, Inc., to consult individuals, groups and/or organizations having information concerning my education, training, qualifications or experience, including malpractice claims history, and to inspect all pertinent documentation. The undersigned hereby releases California Dental Network, Inc., and its representatives and affiliates from any liability for their acts performed in good faith and without malice in evaluating my credentials and qualifications including any malpractice liability claims information, and do hereby further release all individuals and organizations which provide information to California Dental Network, Inc. regarding my professional competence, ethics, character and other qualifications or affiliations, including malpractice claims information, from any liability provided they are acting in good faith and without malice. The undersigned hereby agrees to notify California Dental Network, Inc. in a timely manor of any changes in the above information.

NAME: _____
(Please Print or Type)

Signature: _____ Date: _____

**Provider Application
Dental Facility Information**
(Use a separate form for each Location)

Dental Facility:

Name of Practice _____
(As you want it to appear in our provider directory)

Street Address _____

City _____ County _____ State _____ Zip Code _____

Mailing Address, If Different _____

City _____ County _____ State _____ Zip Code _____

Office Numbers:
Phone (_____) _____ - _____ Fax (_____) _____ - _____

Legal Entity: Corporation _____ Partnership _____ Sole Proprietor _____ Tax I.D. Number _____

Principal Owner(s):	Dental License #
_____	_____
_____	_____

Principal Contacts:

Dentist _____ Phone (_____) _____ - _____ Ext. _____

Administrator _____ Phone (_____) _____ - _____ Ext. _____

Staffing:

Office Staff (FTE's):
Dentists _____ Hygienists _____ RDA's/DA's _____ Admin Staff _____

Associate Dentist(s) Name	Dental License #	Specialty	Hours/Week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Complete an "Individual Dentist Information" form for each Owner and Associate)

Availability/Capacity:

Office Hours:
Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____ Sat: _____ Sun: _____

of Operatories: _____ Patient Base: _____ FFS/Indemnity _____% Prepaid _____% Denti-Cal _____%

Other Managed Care Plans Accepted: _____

Appointment availability: New Patient _____ Routine _____ Hygiene _____ Emergency _____

Foreign Languages Spoken: _____

Accessibility:

Location:

Ground Floor: _____ 2nd or Higher: _____ Elevator: Yes ___ No ___ N/A ___

Free Parking: Yes ___ No ___ # of Parking Spaces: _____ On site restrooms: Yes ___ No ___

Handicap accessible:

Parking: Yes ___ No ___ Restrooms: Yes ___ No ___ Front Door: Yes ___ No ___

Elevator: Yes ___ No ___ Operatories: Yes ___ No ___ X-Rays: Yes ___ No ___

Routine appointment intervals: _____ Average waiting time in office with appointment: _____

Appointments per dentist/day: _____ Describe broken appointment policy & follow up system:

Are emergency services available 24 hours a day: Yes ___ No ___

Describe how you provide for emergency services in your absence: _____

Specialists to whom your Practice refers patients:

Endodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Periodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Oral Surgeon: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Pedodontist: Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Name: _____ Address: _____

_____ Phone: (____) _____ - _____

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Please print or type	Name (See Specific Instructions on page 2.)	
	Business name, if different from above. (See Specific Instructions on page 2.)	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		

Part I Taxpayer Identification Number (TIN)	List account number(s) here (optional)																																				
<p>Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.</p> <p>Note: <i>If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.</i></p> <div style="text-align: center;"> <table border="1" style="margin: 0 auto; border-collapse: collapse;"> <tr><td colspan="9" style="text-align: center;">Social security number</td></tr> <tr><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td></tr> </table> <p style="margin: 5px 0;">or</p> <table border="1" style="margin: 0 auto; border-collapse: collapse;"> <tr><td colspan="9" style="text-align: center;">Employer identification number</td></tr> <tr><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td></tr> </table> </div>	Social security number																		Employer identification number																		Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)
Social security number																																					
Employer identification number																																					

Part III Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **and**
- I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

- You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all

such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to

report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

