GUARDIAN DENTAL NETWORKS

CENTRALIZED CREDENTIALNG PROVIDER APPLICATION

Centralizing credentialing across our enterprise is just another way we are making it easier to do business with us.

This application will be processed by Guardian Life Insurance Company of America ("Guardian"). Serving as the guardian of your credentials, all communications regarding this application and future credentialing events will be communicated to you by Guardian and shared only with those Guardian companies where you have expressed an interest in becoming a participating provider or have an existing contractual relationship.

THE GUARDIAN INSURANCE COMPANY OF AMERICA P.O. Box 981574 El Paso, TX 79998-1574

General Information

Please complete all relevant fields.

First Name	Middle Name	Last Name	Suffix	Degree Title

Contact Email Address	Fax

Gender			Social Security Number
☐ Male	☐ Female	☐ Other	
Birth Date			**NPI-1**
Medicare Number			**Medicaid Number**

Home Address

Please enter your home address in full.

Home Address Line 1
Home Address Line 2

City	State	Zip

Other Names

Please enter any other names by which you have been known.

First Name	Middle Name	Last Name	From Date	To Date

Licensure

Please list all current and past licenses.

License Type	License Number

License Status		
☐ Active	☐ Inactive	☐ Expired

State	Issue Date	Expiration Date

License Type	License Number

License Status

State	Issue Date	Expiration Date

DEA Registration

Please provide details of all DEA registrations.

DEA Number	Status

State	Issue Date	Expiration Date

DEA Number	Status

State	Issue Date	Expiration Date

Controlled Substance Certificate

Please provide details of all CSC registrations.

Number		Status
State	**Issue Date**	**Expiration Date**

Anesthesia Permit

Please provide details of all Anesthesia Permits

Number		Status
State	**Issue Date**	**Expiration Date**

ECFMG

Where applicable, please provide any Educational Commission for Foreign Medical Graduates details below.

Name on Certificate	ECFMG Number	Issue Date

Additional or Other Certification

Please provide details of any other certifications

Certificate Type		Certificate Number
State	**Issue Date**	**Expiration Date**

Certificate Type		Certificate Number
State	**Issue Date**	**Expiration Date**

Service Location

Please provide full details of any relevant office.

Address Type				
☐ Primary Practice Location	☐ Other Practice Location			
Practice Type				
☐ FQHC	☐ Mobile	☐ Indian Health Clinic	☐ Ryan White	☐ Family Planning
Practice Name				
Address Line 1				
Address Line 2				
City	**State**	**Zip**		
Tax ID	**Phone**	**Fax**		
Credentialing Contact	**Contact Phone**	**Contact Email**		
Web Site URL	**Group NPI-2**			

Credit Cards Accepted					
☐ American Express	☐ Care Credit	☐ Discover Card	☐ MasterCard	☐ Visa	☐ Other

Emergency & Patient Access Services							
Are emergency services available 24 hours a day?	☐ Yes	☐ No	Method of Access	☐ Answering Service	☐ Urgent Care	☐ Emergency Phone #	☐ Emergency Room
Accepts patients with Special Needs and/or disabilities?	☐ Yes	☐ No	TTY Available	☐ Yes		☐ No	
Handicap accessible office (ADA compliant)?	☐ Yes	☐ No	Handicap parking available?	☐ Yes		☐ No	
Provides or staff CPR certified?	☐ Yes	☐ No	Accepts new patients?	☐ Yes		☐ No	
Age of patients accepted	From		To				

Service Location (continued)

Please indicate practice capabilities

Endodontics	Anterior root canal treatment		**Oral Surgery**	Erupted tooth surgical removal	
	Bicuspid root canal treatment			Impaction tooth removal	
	Molar root canal treatment		**Periodontics**	Surgical periodontal services	
Restorative	Amalgam restorations			Scaling and root planning	
	Composite restorations		**Pediatric Dentistry**	Routine care < 8 years old	
				Routine care > 8 years old	

Please indicate which services are offered at this location.

Nitrous Oxide	☐ Yes	☐ No	
General Anesthesia	☐ Yes	☐ No	
IV Sedation	☐ Yes	☐ No	
Oral Sedation	☐ Yes	☐ No	
Panoramic X-ray	☐ Yes	☐ No	
Intraoral X-ray	☐ Yes	☐ No	
Electronic claim submission	☐ Yes	☐ No	
Digital radiograph submission	☐ Yes	☐ No	
Sterilization method	☐ Auto clave	☐ Chem clave	☐ Other

Please indicate all non-English languages spoken at this location.

Language 1	Language 2	Language 3

Please provide the hours during which you practice at this location

	AM Open	AM Close	PM Open	PM Close
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Correspondence Address

Please indicate the address you would like all written communications mailed to.

Practice Name		
Address Line 1		
Address Line 2		
City	**State**	**Zip**
Tax ID	**Phone**	**Fax**
Office Manager		**Phone**
Office Manager's Email Address		

Billing Address

Please indicate the address you would like all payment remittances mailed to.

Practice Name		
Address Line 1		
Address Line 2		
City	**State**	**Zip**
Tax ID	**Phone**	**Fax**
Billing Manager		**Phone**
Billing Manager's Email Address		

Provider Specialty

Please indicate area of practice.

Primary Specialty

Board Certification ☐ Not Applicable

Please complete all relevant fields.

Name of Board		
Board Status	**Lifetime Certified**	
	☐ Yes	☐ No
Certification Date	**Expiration Date**	

Education

Please complete all relevant fields. Allied Health Professionals must include undergraduate education.

Education Type			Degree Earned
☐ Undergraduate	☐ Graduate	☐ Post Graduate	
Institution Name			**Date From/To (MM/YY format)**
Address Line 1			
City	**State**	**Zip**	**Country (if non-US)**

Education Type			Degree Earned
☐ Undergraduate	☐ Graduate	☐ Post Graduate	
Institution Name			**Date From/To (MM/YY format)**
Address Line 1			
City	**State**	**Zip**	**Country (if non-US)**

Work History

Please list all places of clinical practice and/or employment since completion of training, over the last five (5) years. Please begin with the most current and list in chronological order. Please explain any gaps greater than six (6) months or more on a separate piece of paper. ***If practicing in Georgia or Pennsylvania, please explain any gaps in work history greater than thirty (30) days.***

Date From/To (MM/YY format)	Employer	Address (City, State)	Phone	Can employer to contacted?	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

Work Gap Explanation:

From/To (MM/YY format)	Explanation

Liability Insurance

Please list all professional liability insurance carriers, including any tort or patient compensation fund programs.
A current copy of the professional liability coverage, including the amounts, policy dates and provider's name for each policy listed below must be submitted with this application.

Carrier Name	
Policy Number	**Coverage Type**
Effective Date	**Expiration Date**
Per Claim Limit	**Aggregate Limit**

Carrier Name	
Policy Number	**Coverage Type**
Effective Date	**Expiration Date**
Per Claim Limit	**Aggregate Limit**

Professional Claims History

Do you have, or have you ever had any claims of malpractice which have been commenced against you, whether closed or currently open?	☐ Yes	☐ No
Please indicate the number of separate claim explanations submitted with this application:		
If you indicated that you have any claims, please complete a separate Professional Liability Claims information section for each open or closed claim. Please copy that page for each additional claim you have. By signing below, you acknowledge that you have no claims to disclose or that the number of claims indicated above is correct.		

Provider's Original Signature *Date*

Note: Stamped Signatures will not be accepted

Professional Liability Claims Information

Please provide a detailed explanation below for each open or closed. Copy this page for each additional claim you have.

NOTE: Explanation must be provided by the Provider.

CLAIM NUMBER _____ OF _____:

Reporting Institution Name or Claimant				
Date of Incident	**Date Claim Filed**	**Claim Status**		
		☐ Pending	☐ Settled	☐ Dismissed
Description of Case				
Provider Statement				
Judgement Description				
Judgement Date	**Judgement Amount**			
Provider's Original Signature			**Date**	

Note: Stamped Signatures will not be accepted

Attestation Questions

Please answer each of the following questions. Any question answered adversely will require a detailed explanation.

	Yes	No
1. Have any of the following ever been or are currently under investigation, either on a voluntary or involuntary basis (e.g., denied, revoked, suspended, probated, not renewed)?		
a. Medical license in any state or jurisdiction		
b. Other professional registration/license in any state or jurisdiction		
c. Federal DEA Registration		
d. State Controlled Substance Registration		
e. Membership on any hospital/healthcare facility medical/professional staff		
f. Clinical Privileges		
g. Participation in the Medicare/Medicaid program(s)		
h. Membership in other health care organizations or plans (PHO, MSO, HMO, ASC)		
i. Professional society membership		
j. Board Certification		
k. ECFMG Certification		
l. Prerogatives/rights on any medical staff		
m. Any other type of professional sanction		
2. Have you ever pled guilty, pled no contest, been convicted or are presently indicted for a felony?		
3. Have you ever been arrested (even if the record has been expunged)?		
4. Have there ever been any misdemeanor/felony criminal charges brought against you?		
5. Has any claim of sexual harassment or violation of civil rights ever been made against you that resulted in you receiving or incurring any warning, disciplinary action, or civil liability?		
6. Have you ever been denied professional liability insurance or has your coverage ever been canceled or not renewed?		
7. Has any professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or otherwise restrict your coverage?		
8. Are there any privileges you are requesting which are not covered by your professional liability insurance?		
9. Have any professional liability suits filed resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability?		
10. Have you ever settled any professional liability claim against you prior to suit and admitted liability as part of such settlement?		
11. Are you now or have you ever engaged in the illegal use of controlled substances?		
12. Are you currently or have you ever participated in a supervised rehabilitation program or professional assistance program as a patient?		
13. Has a suit been filed against an institution or entity based upon alleged negligent medical acts or omissions by you within the last ten years (even if dismissed or dropped), other than identified above (e.g. a suit against a teaching hospital, university, governmental entity or other employers)?		
14. Has a settlement been made by an institution based upon alleged negligent medical acts or omissions by you within the last ten years?		
15. Are you currently, or have you ever been, the subject of an individual focused review by a health care facility's Quality Assurance, Utilization Review, Risk Management, Peer Review or similar monitoring committee?		
16. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient?		
17. Have you at any time during the last 10 years been hospitalized or received any other type of institutional care for physical/mental problems?		
18. Do you have a condition that could compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting?		
19. In the last five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page.		
20. Do you monitor your staff member's licenses to verify the licenses are current and without encumbrance?		
21. If you participate in Medicare Advantage and/or Medicaid programs, do you and your staff complete fraud, waste and abuse training upon hire and annually thereafter?		
22. If you participate in Medicare Advantage and/or Medicaid programs, do you and your staff complete cultural competency training upon hire and annually thereafter?		

Attestation and Authorization Release Form

I attest that all the information provided in my Application is true and complete to the best of my knowledge and belief. I will notify The Guardian (as defined below) within 10 days of any material changes to the information I have provided or authorized to be released on my behalf. I understand that corrections to my Application are permitted at any time prior to the determination by Guardian and must be submitted on-line or in writing and must be dated and signed by me.

I authorize The Guardian Life Insurance Company of America on behalf of itself and any of its subsidiaries, including: Access Dental Plan, Access Dental Plan of Nevada, Inc., Access Dental Plan of Utah, Inc., Avēsis Incorporated, Avēsis Third Party Administrators, Inc., First Commonwealth, Inc., First Commonwealth Insurance Company, First Commonwealth Limited Health Services Corporation, First Commonwealth Limited Health Services Corporation of Michigan, First Commonwealth of Illinois, Inc., First Commonwealth of Missouri, Inc., Managed Dental Care, Managed DentalGuard, Inc. (New Jersey), Managed DentalGuard, Inc. (Ohio), Managed DentalGuard, Inc. (Texas) and Premier Access Insurance Company, affiliates, successors, employees, contractors, agents, anyone with whom such entities may contract and to whom information on any Application I submit for credentialing purposes may be released on an ongoing and continuing basis (collectively, "Guardian") to obtain information from others, including but not limited to: state licensing authorities, certification boards, the National Practitioner Data Bank (NPB), professional liability and malpractice insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, members of medical or other professional staffs, hospital administrators and health-care-related employers that may be necessary to evaluate my qualifications, including without limitation, my professional competence and conduct, information about disciplinary actions and information that might otherwise be considered confidential or privileged (collectively, "Credentialing Information").

I authorize Guardian to request and receive verification of Credentialing Information and authorize Guardian to monitor my credentials on an ongoing and continuing basis. I understand that I have the burden of providing adequate and accurate information to demonstrate my qualifications and that statements written on my Application will be considered statements made by me, even if prepared by another, including but not limited to an employee, agent or representative.

I attest that the information contained in my Application is correct and complete and understand that any misstatement or omission may constitute grounds for rejection of my Application or dismissal as a Participating Provider with Guardian or its client-sponsored networks. I understand that it is my ongoing obligation to immediately notify Guardian: (i) of any changes to the information provided in my Application (including but not limited to changes to professional liability insurance, malpractice status, physical or mental condition, or state dental license status), or (ii) if I have reason to believe or become aware that any information provided is inaccurate or inadequate. I understand that if Guardian denies my Application or otherwise takes action that is averse to my request for participation, Guardian may be obligated, under applicable law, to report such action to the NPDB and/or other licensing or accreditation agencies. I authorize Guardian to disclose all Credentialing Information to its members, payor clients or other entities who may lease a Provider Network from Guardian, subject to applicable law, rules and regulations. I understand that credentialing requirements may vary from state to state and additional information may be required. I release Guardian from all liability for acts performed in good faith and without malice. I agree that a digital image of my Application including this Form, as executed, shall be considered as a true and correct original and admissible as best evidence to the extent permitted by a court with proper jurisdiction.

Print Provider's Full Name	
Provider's Original Signature	**Date**

Note: Stamped signatures will not be accepted

Credentials Verification Release

Provider Name

I, the undersigned Provider, authorize The Guardian Life Insurance Company of America ("Guardian") , to whom information on this Application may be released on an ongoing and continuing basis, as well as to its affiliates, subsidiaries, successors, employees, contractors, agents and anyone with whom it may enter into a contract with (collectively, "Representatives") to obtain information from others, including but not limited to: state licensing authorities, certification boards, National Practitioner Data Bank (NPB), professional liability and malpractice insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, members of medical or other professional staffs, hospital administrators and health-care-related employers that may be necessary to evaluate my qualifications, including without limitation, my professional competence and conduct, information about disciplinary actions and information that might otherwise be considered confidential or privileged (collectively, "Credentialing Information"). I authorize Guardian to request and receive verification of Credential Information and authorize Guardian to monitor my credentials on an ongoing and continuing basis. I understand that I have the burden of providing adequate and accurate information to demonstrate my qualifications and that statements written on this application will be considered statements made by me, even if prepared by another, including but not limited to an employee, agent or representative. I attest that the information contained in this application is correct and complete and understand that any misstatement or omission on this application may constitute grounds for rejection of my application or dismissal as Participating Provider with Guardian's or its client-sponsored networks. I understand that it is my ongoing obligation to immediately notify Guardian: (i) of any changes to the information provided (including but not limited to changes to professional liability insurance, malpractice status, physical or mental condition, or state dental license status), or (ii) if I have reason to believe or become aware that any information provided is inaccurate or inadequate. I understand that if Guardian denies my application or otherwise takes action that is adverse to my request for participation, Guardian may be obligated, under applicable law, to report such action to the NPDB and/or other licensing or accreditation agencies. I authorize Guardian to disclose any and all Credentialing Information to its members, payor clients or other entities who may lease a Provider Network from Guardian, subject to applicable law, rules and regulations. I understand that credentialing requirements may vary from state to state and additional information may be required. I release Guardian from any and all liability for acts performed in good faith and without malice in obtaining and verifying the information collected and evaluating my application. I agree that a digital image of this document, as executed, shall be considered as a true and correct original and admissible as best evidence to the extent permitted by a court with proper jurisdiction. (Note: Stamped signatures will not be accepted)

Signature	Date
Printed Name	
Address	
Phone	

A photocopy of this consent shall be as effective as the original when so presented.

Disclosure of Ownership Form
Individual

This form is to be used when applying for network participation as an individual provider or at the time of re-credentialing if contracted on an individual basis with Guardian and/or a Guardian entity. If the addition of an individual provider to an existing entity will change the ownership or control structure of such entity, then a new disclosure form for the entity must be completed to reflect the new ownership or control structure. For example, the new individual provider will be an owner or high-ranking employee of the existing entity.

Please answer all questions as they pertain to the date the form is being completed. If additional space is needed, please note on the form the answer is being continued on a separate attachment and reference the item number on the attachment being continued. Please return the original document to Guardian and retain a copy for your files. Respond to all applicable questions and respond N/A to any question not applicable. NO QUESTIONS CAN BE LEFT BLANK.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).

I. IDENTIFYING INFORMATION

Provider's Full Name	**SSN**	**Date of Birth**	**National Provider Identifier (NPI)**	**Medicaid Identification Number**
Provider's Home Address		**City**	**State**	**Zip Code**

Entity Name *(This is whom the Individual Provider is employed by. If Individual Provider is sole proprietor, then list Individual Provider as entity.)*		**Entity D.B.A Name** *(Only complete if different from Entity Name)*	**Entity Federal Tax Identification Number**
Entity NPI	**Medicaid Identification Number**	**Entity Address** *(If more than one (1) practice location, list all locations)*	

II. CRIMINAL OFFENSE ATTESTATION

A) Have you ever been **convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, SCHIP or the Title XX services program since the inception of those programs? "Convicted" means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pretrial diversion or suspended sentence.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Name on Court Record	SSN	Description of Offense	Date of Conviction	Sanction Period *If Sanctioned by Office of the Inspector General (OIG)*

B) Have you ever been **debarred** from participation in federal government contracts? **Debarred** means you are not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Date Debarred	Length of Debarment	Reason for Debarment

C) Have you ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, SCHIP or TRICARE) in the past? **Excluded** means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Date Excluded	Date of Reinstatement	Reason for Exclusion

D) Have you ever been **terminated** from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a state's Medicaid or SCHIP program for a cause related to fraud or abuse.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Issuing Termination	Date of Termination	Reason for Termination

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Assessing CMP	Date of CMP	Amount of CMP	Reason for CMP

III. QUESTIONS FOR A SOLE PROPRIETOR

A) If you are a sole proprietor, please give the following information for your managing employees and agents. A managing employee is someone who makes day-to-day decisions on the running of your business such as an office manager or billing manager. An agent is someone besides yourself who can legally act for your business.

Managing Employee or Agent Name	**SSN**	**DOB**	**Complete Home Address** (Street, City, State and Zip)

B) Has any person listed in question 3A ever been **convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? **Convicted** means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pretrial diversion or suspended sentence.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Managing Employee or Agent's Full Name	**Date Convicted**	**Sanction Period Issued by Office of Inspector General**	**Explanation of Offense**	

C) Has anyone on the list in question 3A ever been **debarred** from participation in federal government contracts? **Debarred** means someone is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Managing Employee or Agent's Full Name	**Date of Debarment**	**Length of Debarment**	**Reason for Debarment**

D) Has any person on the list in question 3A ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	**Date Excluded**	**Date of Reinstatement**	**Reason for Exclusion**

E) Has anyone on the list in question 3A ever been **terminated** from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	State Issuing Termination	Date of Termination	Reason for Termination

F) Has any person on the list in question 3A ever had a **Civil Monetary Penalties** (CMPs) assessed against them?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	State Assessing	Date of CMP	Amount of CMP	Reason for CMP

IV. Signature

Guardian and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106.

THE SIGNATURE BELOW MUST BE THE WRITTEN SIGNATURE OF THE PROVIDER.

In compliance with 42 CFR 455.104c, Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of re-credentialing/re-enrollment, and within 35-days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

Name Individual Provider (printed)	Signature of Individual Provider STAMPED SIGNATURE NOT ACCEPTABLE	Date

Authorized Individual Completing Form (printed)	Title of Authorized Individual Completing Form
Phone Number of Authorized Individual	**Email of Authorized Individual**

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. 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
2. 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
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*