GETTING STARTED ...

Maverest contracts according to Tax ID Number (TIN). All dentists associated with this participating TIN are considered participating with Maverest.

To become a participating provider with Maverest Dental Network, LLC, you must complete the enclosed forms and provide supporting documentation. In order to prevent delays in your approval process, it is important that the forms be complete and accurate. Please use the checklist below to ensure we have all of the information we need to process your application efficiently.

The forms listed below are required to be completed in order to be considered for participation.

☐ **Office Profile**
Complete one Office Profile for each service address to be listed.

☐ **Dentist Credentialing Information**
Each dentist under your TIN must complete one of these forms. Copies of this form are permitted. Some states require specific credentialing/application forms. If your practice is in CO, KY, LA, MD, NC, NV, OH, OK, OR, TX, VT or WV, you must complete and submit the state-mandated forms instead of the Maverest forms.

☐ **Participating Dentist Agreement**
If there are multiple dentists under your TIN, only one signed agreement is necessary. However, all dentists who will participate under this TIN must complete the Dentist Credentialing Information form (or state-mandated form if applicable) and sign the Attestation Statement.

☐ **Copy of current state dental license** (and specialty certificate and/or board certification if applicable)
Please provide a copy for each dentist.

☐ **Copy of professional liability insurance**
Please provide a copy of the declaration page showing coverage amounts, expiration date, and provider/business name for each dentist under this TIN dentist.

☐ **Copy of your DEA Certification form 223** (and CDS, if applicable for your state)
Please provide a copy of the DEA Certification form 223 for each dentist under this TIN.

☐ **W-9 Form**
Please be sure to indicate your practice/business start date.

☐ **NPI Registry Provider Verification**
Please provide a copy of the NPI Registry Provider Detail page for each dentist and practice. Visit https://npiregistry.cms.hhs.gov/ to print a copy of your registration.

Upon acceptance as a Maverest Dental Network, LLC participating provider, a welcome letter will be mailed to the service address indicated on the Office Profile.

The Maverest Provider Agreement creates a contractual relationship between Maverest Dental Network, LLC and all dentists who practice under the contracted office TIN. Please be advised that any provider in your office who is denied from participating with Maverest due to not meeting Maverest credentialing standards will not be allowed to provide services to Maverest members until s/he has been successfully credentialed by Maverest. All other credentialed providers under the contracted TIN will remain participating providers with Maverest.

Application Mailing Address:
Maverest Dental Network, LLC
P.O. Box 17760
Indianapolis, IN 46217

OFFICE PROFILE

Maverest contracts according to Tax ID Number (TIN). All dentists associated with this participating TIN are considered participating with Maverest. Please type or print all of the information requested on this form. Incomplete forms cannot be accepted and will be returned for completion. Submit only the location(s) associated with this TIN. If there are multiple locations under this one TIN, copy and **complete Office Profile for each location.** ***NOTE: Fields with asterisks (*) indicate a response is required. All other fields will be considered not applicable if left blank.***

Section 1: Participating Dental Office Information

*Tax ID: ______________________ *Programs (check one only): ☐ Basic and Preferred ☐ Basic Only ☐ Preferred Only

*Business Name: ______________________ NPI: ______________________
(Business name must match your name on W-9) (Practice Identifier)

Practice Name: ______________________ Practice Start Date: ______________________
(As will be listed in directory)

*Service Office Street: ______________________ *City: ______________________

*State: ________ *Zip: ________ County: ______________________ *Phone: ______________________

Fax: ______________ E-mail: ______________________ Website: ______________________

Preferred method of contact: ☐ E-mail ☐ Fax ☐ US Mail

Contact Name: ______________________ Contact Phone Number: ______________________

*Payment Address (if different than service address)

Street: ______________________ City: ______________________

State: ________ Zip: ________ County: ______________________ Phone: ______________________

*Physically Disabled Access: ☐ Yes ☐ No *Languages other than English (list) ______________________

*Do you follow the current recommendations of the American Dental Association and the Centers for Disease Control and Prevention regarding infection control? . . . . ☐ Yes ☐ No

If no, explain: ______________________

*Do you comply with the Occupational Exposure to Bloodborne Pathogens Standards of the OSHA regulations? . . . . ☐ Yes ☐ No

If no, explain: ______________________

*Does your office have an intra-oral x-ray unit? . . . . ☐ Yes ☐ No Panoramic x-ray unit? . . . . ☐ Yes ☐ No

*Do you have emergency coverage for patients after hours (e.g. emergency phone number available)? . . . . ☐ Yes ☐ No

*Is someone in your office CPR certified? . . . . ☐ Yes ☐ No

Section 2: Group Practice Members, Partners, and Associates

All practicing dentists associated with the Tax ID listed above are considered participating dentists with the Maverest Dental Network. The following consent to be bound by all provisions of this Agreement. If additional dentists are associated with this TIN beyond the ones listed below, please attach a separate listing to this Agreement. Owner/Dentist is responsible and agrees to notify Maverest of any changes in this list. ***A Dentist Credentialing Information form and Attestation must be completed for each practicing dentist.***

First Name	Last Name	MI	Degree	License #	Specialty

Name: ______________________________
License #: ______________________________
State: ______________________________

DENTIST CREDENTIALING INFORMATION

Please complete all items to avoid having the application returned. This form must be returned for ***each additional dentist in the practice who will be associated with your TIN.*** *Some states require specific credentialing/application forms. If you practice in CO, KY, LA, MD, NC, NV, OH, OK, OR, TX, VT or WV, you must complete and submit the state-mandated forms instead of this form.* ****NOTE: Fields with (*) indicate that a response is required. All other fields should be marked as NA if not applicable.***

Please provide the following information:

*Last Name: ______________________________ *First Name: ______________________________ *MI: ____

*Degree (all that apply): ☐ DDS ☐ DMD ☐ RDH ☐ MS ☐ Other: ______________

*SSN #: ______________ *Date of Birth: ______________ *Gender: ___ National Provider Identifier (NPI): ______________

*Specialty: ☐ General Dentist ☐ Endodontist ☐ Oral Maxillofacial Surgeon ☐ Pediatric Dentist ☐ Radiologist
☐ Orthodontist ☐ Prosthodontist ☐ Periodontist ☐ Public Health ☐ Other: ______________

License and Certification (Please submit copies of license and certificates)

*Current State License Number: ______________ *State: ______ *Expiration Date: ______________

Other Current State License Number: ______________ State: ______ Expiration Date: ______________

*Federal DEA # (if applicable): ______________ Expiration Date: ______________

State CDS # (if applicable): ______________ Expiration Date: ______________

Specialty Certificate: ______________ Specialty Board Certification: ______________ Expiration Date: ______________

*Do you have hospital privileges? ☐ Yes ☐ No ☐ NA

*Hospital Name: ______________ Start Date: ______________ (Month/Year) End Date: ______________ (Month/Year)

Address: ______________ Street ______________ City ______________ State ______________ Zip

Do you perform general anesthesia? ☐ Yes ☐ No Are you certified? ☐ Yes ☐ No Expiration Date: ______________

***Education and Training**

Dental School Name: ______________ City: ______________ State: ______ Zip: ______________

Graduation Year: ______________ Degree Awarded: ______________

Post Graduate/Specialty Training

Institution Name: ______________ City: ______________ State: ______ Zip: ______________

Start Date: ______________ (Month/Year) Completion Date: ______________ (Month/Year) Did you successfully complete the program?: ☐ Yes ☐ No

Type of Training: ☐ General Practice ☐ Endodontics ☐ Oral Maxillofacial Surgery ☐ Pediatric Dentistry ☐ Oral Radiology
☐ Orthodontics ☐ Prosthodontics ☐ Periodontics ☐ Public Health

Board Certified: .... ☐ Yes ☐ No Certifying Board: ______________

***Professional Liability Insurance** (Please submit a copy of your current professional liability declaration showing coverage amounts, expiration date, and provider name)

Carrier(s) Name: ______________ Policy #: ______________

Limits of Coverage: $______________/$______________ Effective Date: ______________ Expiration Date: ______________

****Work History: List all employment for the past 5 years or provide a resume/curriculum vitae. To facilitate the credentialing process, please fill in the month and year. All gaps greater than 6 months are required to be explained on a separate sheet.***

Practice/Employer	City	State	Month/Year to Present
Practice/Employer	City	State	Month/Year to Present
Practice/Employer	City	State	Month/Year to Present

Name: ______________________________

License #: ______________________________

State: ______________________________

***Professional Information**

Question	Yes	No
Have you been involved in a malpractice suit or claim within the last 10 years or do you have any claims pending? (Include dates, nature of suit, amount of the settlement, and explanation)	☐ Yes	☐ No
Has your license to practice dentistry in any state ever been revoked, suspended, restricted, limited, or placed in a probationary state?	☐ Yes	☐ No
Have you ever been reprimanded, disciplined, counseled, or been subject to similar action by any state licensing agency with respect to your license to practice?	☐ Yes	☐ No
Are you currently under any investigation with respect to your Drug Enforcement Agency (DEA) license or has your DEA license ever been revoked, suspended, or placed on probation?	☐ Yes	☐ No
Have you ever been subject to sanctions by Medicare, Medicaid or any other state or federal program?	☐ Yes	☐ No
Have you ever been convicted of a felony or do you have any criminal charges pending other than for minor traffic offenses?	☐ Yes	☐ No
Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to patient safety or health, with or without reasonable accommodation?	☐ Yes	☐ No
Are you currently using illegal substances or are you dependent on alcohol, drugs, or illegal substances?	☐ Yes	☐ No
Have you ever had hospital privileges denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions?	☐ Yes	☐ No

If you answered yes to any of these questions, please provide an explanation on a separate sheet.

DENTIST ATTESTATION STATEMENT

Maverest only contracts according to Tax ID Number (TIN). All dentists associated with this participating TIN are considered participating with Maverest. By signing below, I hereby apply to become a participating dentist in Maverest Dental Network (MDN) and agree to abide by the terms and conditions of the MDN Participation Agreement. I understand and agree that my execution of this document grants me no rights or privileges of participation until such time as I receive written notification from MDN signifying MDN's acceptance of me or as a participating dentist. By signing this document I agree to bind myself to the terms as set forth in this Agreement. I certify that the information in this Application is complete, accurate, truthful, and correct in all respects. I understand that my application may require MDN to review information related to me, my professional corporation and/or members of my group practice on file with other entities and regulating bodies. I hereby consent to and authorize the release of such information by any such entity that requires authorization.

I authorize the State Board (or other dental licensing agencies in any state in which I am licensed to practice dentistry) and any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to MDN regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence including any privileged or confidential information. I authorize and request my professional liability (malpractice) insurance carrier to release information to MDN regarding any claims or actions for damages pending or closed during the previous ten (10) years whether or not there has been a final disposition. I release from liability and promise not to sue: a) any person or entity who, in good faith and without malice, provides information to MDN for the purpose of evaluating my application, credentials and qualifications; and b) MDN for their acts performed, in good faith and without malice, in connection with the evaluation of my application, credentials and qualifications.

I understand that MDN may require me to provide credentialing information, as necessary, in connection with this application.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, MDN may report the rejection to the appropriate licensing board, NPDB and/or Health Care Integrity and Protection Data Bank.

MDN does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.

I certify that all of the information herein is true and complete to the best of my knowledge and agree to notify MDN, in writing, of any changes in this document, or any applicable document, within ten (10) days of their occurrence. I understand that information that is found to be false or misleading could result in denial/termination of participation status with MDN. I acknowledge this information may also be used for any re-credential process that may be performed by MDN at any time.

*Applicant Signature:______________________________ License #:__________________ State: ______________

*Print Name: ______________________________ *Date: ______________________

MAVEREST DENTAL NETWORK, LLC

PARTICIPATION AGREEMENT

This Participation Agreement, along with the attached Office Profile/Credentialing Form(s) and Attestation Statement(s) (collectively referred to as the "Agreement") is made and entered into on the ______________ (Day) day of ____________________ (Month) 20_____ (Year), by and between ____ ("Participating Dentist") who is duly qualified and licensed to practice dentistry, or a licensed entity to provide dental services in the State of _________________________ and Maverest Dental Network, LLC ("Maverest") .

Maverest is a Preferred Provider Organization ("Network") that provides Maverest Participants access to dental care services provided by Participating Dentists only through Maverest Payers.

Participating Dentist agrees to be available to provide dental care services to Maverest Participants at rates established in the Maverest Fee Schedule included with and attached to this Agreement (which shall be updated from time to time). Maverest shall provide participating Dentist advance notice when the Maverest Fee Schedule changes.

Participating Dentist warrants that Participating Dentist and Participating Dentist's employees, agents and/or representatives (according to their respective responsibilities within Participating Dentist's scope of services) are duly licensed by the State of _____________________ to provide dental care services.

In consideration of the mutual promises contained herein,the parties agree as follows:

SECTION I. DEFINITIONS

A. Maverest Participant shall mean persons eligible to access dental care services through Participating Dentists at a maximum fee as outlined in Section II(A) or Section II(B) below.

B. Maverest Payer shall mean an insurance carrier, claim administrator (TPA), employer, Taft-Hartley fund, ERISA trust, dental network aggregator, or any other entity which has executed an access agreement with Maverest and is responsible for payment of the dental claim and/or dental service provided by a Participating Dentist.

C. Participating Dentist shall mean the owner of the tax identification number (TIN), or their duly authorized agent and/or representatives, and any employees who are licensed to practice dentistry who has executed a Participating Dentist Agreement with Maverest to provide dental care services to Maverest Participants pursuant to the terms and conditions of said Participating Dentist Agreement and the current Maverest Fee Schedule.

D. Network shall mean the Maverest Participating Dentists who have a contractual relationship with Maverest to provide dental care services to Maverest Participants.

SECTION II. PARTICIPATING DENTIST COMPENSATION

A. By checking the box on the attached Office Profile to participate in the "Basic" program, Participating Dentist agrees to charge his or her usual and customary fees for services provided (without discount) regardless of whether the service is a covered benefit or not, unless otherwise prohibited by applicable state law, and to accept a twenty-five percent (25%) discount as payment in full.

B. By checking the box on the attached Office Profile to participate in the "Preferred" program, Participating Dentist agrees to accept the fees specified on the most current Maverest Fee Schedule (which shall be updated from time to time), regardless of whether the service is a covered benefit or not, unless otherwise prohibited by applicable state law.

C. When Participating Dentist accepts payment from a Maverest Payer, Participating Dentist may not charge or collect from the Maverest Participant any amount obligated to be paid by the Maverest Payer or in contradiction of this Agreement, provided that this does not prohibit Participating Dentist from charging and collecting applicable co-payments, coinsurance or deductibles.

D. Participating Dentist acknowledges that Maverest is not liable for co-payments, coinsurance, deductibles, payments for ineligible or non-covered medical or dental services, claim payments, or any other type of payments due to Participating Dentist from a Maverest Payer or Maverest Participant.

E. Participating Dentist shall not charge or collect any fees from a Maverest Participant or Maverest Payer for completing paperwork or impose any late fees on amounts due and owing from Maverest Payers.

F. Participating Dentist authorizes Maverest Payers to deduct from payments due to Participating Dentist such sums as Maverest Payers reasonably determine to be properly due and owing to Maverest Payers as a refund or payment incorrectly made to or claimed by Participating Dentist.

SECTION Ill. PROVISIONS

A. Maverest shall market, maintain and administer the Network and include Participating Dentist's name, address and telephone number along with all Dentists associated with this TIN in the list of Participating Dentists to be distributed to Maverest Payers and Maverest Participants.

B. Maverest shall market the Network to prospective Maverest Payers with the intent of obtaining Maverest Participants who may become patients of the Participating Dentists.

C. Participating Dentist agrees to be available for providing dental care services to verified, eligible Maverest Participants at the at the fees described in section IIA and IIB above. Participating Dentist shall have the right, within the framework of professional ethics, to reject any person seeking his/her professional services.

D. Participating Dentist represents and warrants that he or she is licensed to practice dentistry in the state of practice and that such license has not been suspended, revoked, limited, or sanctioned within the past five (5) years. Participating Dentist further represents and warrants that his or her staff, facilities, and any individual who may provide services covered by this Agreement are licensed as required by law. All of Participating Dentist's rights and obligations under this Agreement are conditioned on the continued maintenance of his or her license with no restrictions. Participating Dentist agrees to notify Maverest within ten (10) business days if there is any change in status in the license, the representations and warranties made herein or of any individual who may provide services under this Agreement.

E. Participating Dentist agrees to perform obligations under this Agreement in a timely fashion with the usual standard of competence, care and concern for the welfare and requirements of Maverest Participants who seek his/her professional services and in accordance with the principles and ethics of the dental profession that apply in the community where dental care services are rendered. Participating Dentist further agrees to provide Maverest Participants dental care services equal in availability and competence to those he/she provides to his/her other patients and shall not differentiate or discriminate in the treatment of Maverest Participants.

F. Participating Dentist agrees to accept and be responsible for his/her own acts or omissions in the professional practice of dentistry as well as those acts or omissions of Participating Dentist's employees and/or agents, and nothing in this Agreement shall be interpreted or construed to place any such responsibility for professional acts or omissions on Maverest. Maverest similarly agrees to accept and be responsible for its own acts or omissions, as well as those of its employees, and nothing in this Agreement shall be interpreted or construed to place any such responsibility on the Participating Dentist.

G. Maverest and Participating Dentist agree to indemnify, defend, and hold harmless the other, its directors, officers, employees, agents, parents, affiliates, subsidiaries, successors, and assigns from and against any and all liabilities, claims, suits, actions, demands, settlements, losses, judgments, costs, damages, and expenses (including reasonable attorneys' fees) arising out of or resulting from, in whole or in part, any acts or omissions of the other, its employees, agents, or any contractors in performing or failing to perform under this Agreement, or any inaccuracy or breach of any representations or warranties of the parties.

H. In the event that Participating Dentist must refer a Maverest Participant to a specialist, Participating Dentist agrees on a "best efforts" basis to refer the Maverest Participant to a specialist who is a Participating Dentist.

I. Maverest and Participating Dentist agree that each party is independent from the other and that the provisions of the Agreement do not create an employer/employee, principal/agent, partnership or joint venture relationship between the parties.

J. This Agreement shall be in effect as of the date approval by Maverest and shall remain in effect unless terminated by either party upon thirty (30) days written notice with or without cause. This Agreement shall automatically terminate in the event Participating Dentist's license to practice dentistry in the state of practice is limited in any way or if Participating Dentist's conduct may result in immediate injury or damage to the health, safety or well-being of any Maverest Participant, subject to final determination by the Maverest Network credentialing committee.

K. All notices, including but not limited to change of address and change of license status shall be submitted in writing and delivered by U.S. Mail postage prepaid to the address below or any new address supplied by the other party or by fax or electronic delivery.

L. Maverest shall have the right to amend this Agreement by providing written or electronic notice. Failure of the Participating Dentist to reasonably object within thirty (30) days of Maverest sending the notice shall constitute acceptance. Objection to the amendment by the Participating Dentist shall be treated as a request to immediately terminate this Agreement upon thirty (30) days notice.

M. Both Maverest and Participating Dentist have the right to enter into similar agreements with other parties or organizations.

N. This Agreement may be assigned only by Maverest. Participating Dentist may not assign this Agreement or any rights accruing hereunder to any other party without the prior written consent of Maverest.

O. Participating Dentist shall maintain complete and detailed patient treatment and financial records which shall be made available to Maverest or Maverest Payers for review upon request. Such records shall be preserved for a minimum of ten (10) years. Participating Dentist shall cooperate with Maverest's utilization review, credentialing and re-credentialing, as well as any grievance procedures that may follow.

P. If any provisions of this Agreement are or become contrary to law, such provisions shall be inoperative, but the remainder of this Agreement shall remain in full force and effect. The waiver by either party of the breach or violation of any provision of this Agreement shall not operate as, nor be construed as, a waiver of any subsequent breach.

Q. This Agreement constitutes the entire contract between the parties and supersedes all previous agreements whether written or oral between the parties.

R. In the event of any dispute arising out of or relating to this Agreement, the parties agree to attempt in good faith to resolve the dispute first by direct negotiation. In the event that direct negotiation is not successful, the parties shall agree to resolve the dispute through binding arbitration as governed by the American Arbitration Association with each party bearing equal costs of the proceeding.

S. Participating Dentist agrees to have in full force and effect, during and after the term of this Agreement, professional liability insurance with respect to the services provided hereunder ("Malpractice Insurance"). Participating Dentist shall immediately notify Maverest of any restrictions or lapse of such Malpractice Insurance.

T. This Agreement shall be governed by the laws of the State of ________________, provided that the Agreement shall be deemed to incorporate any terms and provisions required to be included by law in the state where the Participating Dentist is located, and such required terms and conditions shall supersede any conflicting provisions herein.

SECTION IV. Additional Provisions for Kentucky Participating Dentists

A. Participating Dentist agrees to hold harmless Maverest Participant for non-payment of monies by Maverest Payer including insolvency or breach of agreement by Maverest Payer, and agrees not to bill, collect deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with this Agreement. This provision does not prohibit the collection of deductible amounts, co-payment amounts, coinsurance amounts, and amounts for non-covered services. This clause shall survive the termination of this Agreement between Participating Dentist and Maverest.

B. In the event that Participating Dentist subcontracts with another provider to provide dental care services for a Maverest Participant, dependent of Maverest Participant, or enrollee of a limited health service benefit plan, Participating Dentist agrees to meet all requirements of KRS 304.17C-060 (1)(a), (b), and (c) and that all such subcontract agreements shall be filed with the Kentucky Insurance Commissioner.

Maverest only contracts according to Tax ID Number (TIN). All dentists associated with this participating TIN are considered participating with Maverest. I hereby apply to Maverest Dental Network to become a Participating Dentist. I understand and agree that submission of this Agreement grants me no rights or privileges of participation until such time as I receive written notification from Maverest Dental Network that I have been accepted as a Participating Dentist. Further, I agree that all information submitted to Maverest is accurate, complete and truthful.

PARTICIPATING DENTIST:

____
Name

____
Address

____
City, State, Zip Code

( ) ______________________________
Telephone

X ______________________________
Dentist Signature

____
Date

Print below the name and license number of all dentists associated with this TIN.

Name:	License #/Specialty

If additional dentists are associated with this TIN beyond the ones listed above, please attach a separate listing to this Agreement.

PLEASE COMPLETE, SIGN & RETURN

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

Exemptions (see instructions):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. 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 3. 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 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

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 on page 3.

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

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, 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 provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.