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Guide to Completing the Supplier Information Packet

Dear Prospective Genentech Supplier,

This supplier information packet must be completed in its entirety and returned to Genentech in order to set you up as a supplier. Follow the instructions below and return the completed forms to the Roche / Genentech contact you are working with. If you need assistance with completing the package, reach out to our Procure 2 Pay (P2P) Support Team to contact at +1 650-467-0810 or at p2psupport-d@gene.com.

What's Included in the Packet:

- **W-9 and Supplier Information Form**
  - Supplier/Payee or authorized supplier representative should complete and sign this form an e-signatures are acceptable.
  - Non-US suppliers should not complete page 1, but rather consult their tax advisor and/or refer to the US IRS web site (https://www.irs.gov) for information about required documentation. A completed electronic payment form is required for all non-US suppliers.

- **Electronic Payment Form**
  - Genentech pays all of our suppliers/payees electronically. Electronic payment is required for all Health Care Providers (HCPs).

Answers to Frequently Asked Questions:

- **Who submits the supplier add request for processing?**
  The Roche / Genentech employee who is requesting to work with you as a supplier must complete and submit an internal supplier add form and attach your completed supplier information packet. So be sure to send the completed packet to that contact.

- **Are there early payment options?**
  Genentech offers options for payment sooner than our standard contractual terms. You can learn more about this program by sending an email to earlypayprograms-d@gene.com.

- **What is Genentech's diverse supplier policy?**
  - Roche / Genentech is committed to supplier diversity and inclusion. As such, we are committed to actively fostering a diverse supply base. We invite all supplier applicants to disclose their diverse supplier status as set forth in this packet. Your submission of this information is voluntary.
  - If diverse ownership is disclosed and selected from the list provided on the form, please attach applicable certifications with this packet.
  - The U.S. Small Business Administration sets standards for which companies qualify as "small" businesses. For North American Industry Classification System (NAICS) codes and corresponding company size standards, please refer to this SBA reference: http://www.sba.gov/sites/default/fies/files/Size_Standards_Table.pdf.

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Substitute W-9 & Supplier Information Form

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Please complete this form in its entirety to expedite adding you as a supplier/payee.

* Remittance Name, Address and Zip Code are mandatory fields if payment method is through check.

Supplier Information

Business name (as shown on your income tax return and registered with the IRS)	
Business Name/Disregarded Entity Name (if different from above)	* **Remittance Name (what is shown on the invoice)**
Primary/Headquarter Address	* **Remittance Address (if different than Primary)**
City, State, Zip Code	* **Remittance City, State, Zip Code**
Phone	**Email**

Tax Classification

- ◉ Individual/sole proprietor or single member LLC
- ○ C Corporation
- ○ S Corporation
- ○ Partnership
- ○ Trust/Estate
- ○ LLC (C=C Corp., S=S Corp., P= Partnership)
- ○ Other _____

Exemptions

Exempt payee code (if any): _____

FATCA Exemption reporting code (if any): _____

Taxpayer Identification Number (TIN)	**Dun and Bradstreet Number (DUNS)**
SSN - - **OR** EIN -	

Supplier Diversity

Ownership Representation

Select an option

If you have more than one ownership representation, please select from below

Select an option

Select an option

Select an option

If you are diverse supplier, please register to our supplier diversity portal. Use the link below.

Link: www.gene.com/supplierreg

☐ Yes, I completed my online registration at link provided above ☐ No

Ethnicity Designation (select from dropdown)

Select an option

Provide description of proper ethnicity designation if selected "Other" from provided list above.

_____

Is your business a certified small business per the U.S. Small Business Administration (SBA)?

☐ Yes ☐ No ☐ No - Self-certified only

Small Business Size Standards:
http:// www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf

Is your business a certified diverse owner? If yes, please provide attached certification with this packet.

☐ Yes ☐ No

Supplier Code of Conduct

☐ **I have read and acknowledged the supplier code of conduct.**

Link to supplier code of conduct: **https://www.roche.com/about/sustainability/suppliers/code-of-conduct**

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 in the instructions), and 4) The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.
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 and you have not received notice from the service that backup withholding is terminated. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature of U.S. Person	**Date**
Signer's Printed Name	**Title**

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HEALTHCARE PROVIDER INFORMATION

- If you are a healthcare provider (HCP), health care organization (HCO), association / charitable entity or third party making payments or providing something of value to or on behalf of an HCP or HCO, please reply to the questions below.

SUNSHINE ACT / OPEN PAYMENTS TRANSPARENCY INFORMATION

- Roche/Genentech is obligated to disclose payments to U.S. Licensed HCPs and other specified covered recipients, including the provision of non-monetary items of value, as required under applicable federal or state laws or regulations, including but not limited to, the Open Payment/Sunshine Act.
- The Roche/Genentech is committed to ensuring that the data we report is as accurate as possible, and we employ extensive processes to collect and review the data prior to submission.
- For additional information pertaining to this please visit : https://www.gene.com/medical-professionals/sunshine-act-compliance

Healthcare Provider Selection Type (completion of this section is mandatory)

Do you or your organization meet any of the following descriptions?

☐ No

☐ Yes (Please select one of the options below)

☐	1. Prescribers and Pharmacists with an active license (HCP – Healthcare Professional) Select an option You must provide either one of the following: 10-digit National Provider Identification Number) : _____ State License Number (in your primary state of practice) : _____ Specify State :	Prescribers as defined by state and/or federal law (e.g., MDs, MDs, DOs, Physician's Assistants, Dentists, Podiatrists, Optometrists, APRN to include Nurse Practitioners), Pharmacists, and students in training programs related to the professions described here.
☐	2. Healthcare Organization	Include university hospitals, general hospitals, medical clinics and healthcare facilities
☐	3. Associations/Charitable Entities	Includes foundations, associations (healthcare related; research / medical / patient / professional society)
☐	4. A third-party making payments (e.g. compensation, honoraria) or providing something of value (e.g., a meal, snack, book) whether a main component of your services, or only on an occasional or ad hoc basis, to or on behalf of an HCP /HCO	E.g., Clinical Research Organization, Investigator Initiated Research Studies, Advisory Boards

HCP Ownership

Does your organization meet one of the above criteria in points 1 to 4? If yes, please indicate the ownership you have:

- A payment is being made to an entity that is wholly-owned by an HCP. The entity is also considered an HCP and information should be categorized as such (Individual, LLC) and noted above by providing HCP details requested above to include Name, NPI or State Licensure
- A payment is being made to an entity that is partially-owned by an HCP. If you select this option, a member of our Aggregate Spend team will reach out to you directly for further clarification to determine reportability obligations to Center for Medicaid Services (CMS).

Select an option

Ordering **location** and **Electronic Payment Form**

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This form is required for all suppliers and Healthcare Professionals (HCP).

eSignatures are accepted.

ORDERING INFORMATION

Sales contact: _____ City, state : _____

PO Email (distribution list email preferred): _____ Zip code : _____

PO address (if different than primary): _____

Type of Request ◉ **NEW** ○ **CHANGE**

VENDOR/PAYEE INFORMATION

Company/Payee Name: _____

Employer Identification Number/Social Security Number: _____

Address: _____

City: _____ State/Province: _____ Postal Code: _____

Country: _____ Telephone Number: _____

Billing Contact Person(s): _____

Email address for remittance advice: _____
* A group email address is encouraged to allow multiple people to receive or access the remittance information. Email notification is sent upon payment processing

BANK ACCOUNT INFORMATION (Provide bank account details for each account and/or currency billed. Submit one form per currency and/or bank)

ACCOUNT TYPE (Please check one): ◉ CHECKING ○ SAVINGS

Payment Currency (select one): USD - US Dollar

Payment Method (Please check one): ◉ ACH / EFT ○ CHECK ○ VIRTUAL CREDIT CARD other currency: _____

Bank Routing ID / Sort code / ABA#: _____

Bank Account #: _____

Swift / BIC #: _____

IBAN (European Countries): _____

Canada only: Bank Branch & ID#: _____

Example: 0001, Local branch, #45689

Bank Name: _____

Branch Name: _____

Bank Address: _____

Bank City: _____

Bank Country: _____

Account holder name: _____

INTERMEDIARY BANK ACCOUNT INFORMATION Do you require an intermediary bank? ○ No ○ Yes (please complete following information)

Bank Name: _____

Intermediary Bank Country*: _____

Intermediary Bank Account #: _____

Intermediary Bank Swift Code: _____ OR Intermediary Bank routing ID # / ABA # _____
* If Intermediary bank is located in the United States provide **BOTH** Swift Code and ABA #

☐ **I request the above banking information to be effective for ALL "remit to" sites with the same Tax Identification number.**

(Note: If this banking information does not pertain to ALL "remit to" sites, please provide a list of specific sites for this information).

IMPORTANT NOTE: Payments made in the vendor's domestic currency will be paid by local electronic payment. Other than in the U.S., these payments will state, "Roche Finanz AG on behalf of Genentech." Payments in a currency foreign to the vendor will be made by wire, however THE LOCAL BANK ID IS STILL REQUIRED FOR BOTH TYPES OF PAYMENTS to be setup in Genentech's/Roche's system.

Vendor will give thirty (30) calendar days advance notice in writing to Genentech, of any changes in it's depository institution or other payment instructions. Failure to provide change notification will result in delayed payments.

Approver's Name (Please print): _____ Title: _____

Approver's Signature: _____ Date: _____

☐ I certify that the above is correct and true, and that I, as a representative for the above named company, hereby authorize Genentech to electronically deposit payments to the bank identified above.

_____