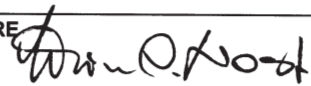


PAYEE DATA RECORD(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003)

| | | | |
|--|--|--|---|
| 1 | INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form. | | |
| 2 | PAYEE'S LEGAL BUSINESS NAME (Type or Print) Newport Stationers, Inc. | | |
| | SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) | | E-MAIL ADDRESS cwest@newportstationers.com |
| | MAILING ADDRESS 17681 Mitchell North, Suite 120 | | BUSINESS ADDRESS 17681 Mitchell North, Suite 120 |
| | CITY, STATE, ZIP CODE Irvine, CA 92614 | | CITY, STATE, ZIP CODE |
| 3 | ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 95 - 2628732 | | NOTE: Payment will not be processed without an accompanying taxpayer I.D. number. |
| <input type="checkbox"/> PARTNERSHIP | | <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) | |
| <input type="checkbox"/> ESTATE OR TRUST | | <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input checked="" type="checkbox"/> ALL OTHERS | |
| CHECK ONE BOX ONLY | | <input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: | |
| (SSN required by authority of California Revenue and Tax Code Section 18646) | | | |
| 4 | <input checked="" type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California. <input type="checkbox"/> California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding. | | |
| PAYEE RESIDENCY STATUS | | <input type="checkbox"/> No services performed in California. <input type="checkbox"/> Copy of Franchise Tax Board waiver of State withholding attached. | |
| 5 | I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below. | | |
| AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Colin West | | TITLE Vice President Treasurer | |
| SIGNATURE  | | DATE 05/21/2009 | TELEPHONE (949) 863-1200 |
| 6 | Please return completed form to: Department/Office: _____ Unit/Section: _____ Mailing Address: _____ City/State/Zip: _____ Telephone: (____) _____ Fax: (____) _____ E-mail Address: _____ | | |