

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)
 Gateway Companies, Inc.

SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) **E-MAIL ADDRESS**
 www.gateway.com

MAILING ADDRESS **BUSINESS ADDRESS**
 7565 Irvine Center Drive 7565 Irvine Center Drive

CITY, STATE, ZIP CODE **CITY, STATE, ZIP CODE**
 Irvine, CA 92618 Irvine, CA 92618

3 **PAYEE ENTITY TYPE**

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 46-0431398

PARTNERSHIP **CORPORATION:**
 ESTATE OR TRUST **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
 LEGAL (e.g., attorney services)
 EXEMPT (nonprofit)
 ALL OTHERS

INDIVIDUAL OR SOLE PROPRIETOR **ENTER SOCIAL SECURITY NUMBER:** _____
 (SSN required by authority of California Revenue and Tax Code Section 18646)

CHECK ONE BOX ONLY

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4 **PAYEE RESIDENCY STATUS**

California resident - Qualified to do business in California or maintains a permanent place of business in California.
 California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
 No services performed in California.
 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) **TITLE**
 Scott M. Sherrick Director, Operations Offer Development

SIGNATURE **DATE** **TELEPHONE**
 04/06/2005 (800) 779-2000

6 Please return completed form to:

Department/Office: _____
Unit/Section: _____
Mailing Address: _____
City/State/Zip: _____
Telephone: (____) _____ **Fax:** (____) _____
E-mail Address: _____