


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) Northrop Grumman Information Technology, Inc.		
	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)		E-MAIL ADDRESS
	MAILING ADDRESS / BUSINESS ADDRESS 15010 Conference Center Drive		ADDRESS - INVOICE REMITTANCE PO Box 26085
	CITY, STATE, ZIP CODE Chantilly, VA 20151		CITY, STATE, ZIP CODE New York, NY 10087-6085
3	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 95 - 2126773		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
PAYEE ENTITY TYPE CHECK ONE BOX ONLY	<input type="checkbox"/> PARTNERSHIP CORPORATION: <input type="checkbox"/> ESTATE OR TRUST <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> <input type="checkbox"/> EXEMPT (nonprofit) <input checked="" type="checkbox"/> ALL OTHERS		
	<input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: - - <small>(SSN required by authority of California Revenue and Tax Code Section 18646)</small>		
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. <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) Duane M. Fletcher		TITLE Contracts Manager
	SIGNATURE 	DATE 06/07/2007	TELEPHONE (206) 388-6370
6	Please return completed form to: Department/Office: _____ Unit/Section: _____ Mailing Address: _____ City/State/Zip: _____ Telephone: (____) _____ Fax: (____) _____ E-mail Address: _____		