Government of the District of Columbia

2019 D-2440 SUB Disability Income Exclusion

1 9 2 4 0 0 S 1 0 0 0 1

Important: Print in CAPITAL letters using black ink.
Leave lines blank that do not apply.

SOFTWARE DEVELOPER'S USE ONLY Vendor #1234

Name as shown on Form D-40
ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKLXXXX

Taxpayer identification number (TIN)
123456789

Personal information

Dateof your birth (MMDDYYYY)	Date youretired (MMDDYYYY)	Name of your employer	Payor, if other than employer
00000000	00000000	ABCDEFGHIJKLABCDEFGH	ABCDEFGHIJKLABCDEFGH

Dateof spouses/registered domestic partner's birth (MMDDYYYY)	Date retired(MMDDYYYY)	Name of employer	Payor, if other than employer
00000000	00000000	ABCDEFGHIJKLABCDEFGH	ABCDEFGHIJKLABCDEFGH

Have you filed a physician's certification for this disability in previous years? X Yes X No

If *yes*, do not file another certification. If *no*, you must file the physician's certification provided below.

Income

If married or registered domestic partners, use both columns. Round cents to nearest dollar. If amount is zero, leave line blank.

			You	*Your spouse*/registered *domestic partner*
1	**Total amount of disability payments received in 2019**	1	$ 123456789.00	$ 123456789.00
2	Multiply $100 by the number of weeks you received disability payments in2019. If you received pay for part of a week, see the Line 2 instructions.	2	$ 123456789.00	$ 123456789.00
3	Enter Line 1 or Line 2 amount, whichever is less.	3	$ 123456789.00	$ 123456789.00
4	*Add the amounts for you and your spouse/registered domestic partner from Line 3.*		*Total income* 4	$ 123456789.00

Limitation on exclusion

5	**Federal adjusted gross income** *from Form D-40, Line 4.* Mark if loss X	5	$ 123456789.00
6	**Taxable social security income** *from Form D-40, Line 10.*	6	$ 123456789.00
7	Subtract Line 6 from Line 5.	7	$ 123456789.00
8	Amount used to reduce the excludable disability income.		- 15000.00
9	Subtract Line 8 from Line 7. **If zero or a negative number, stop here. Do not file this form.**	9	$ 123456789.00
10	**Disability income payment excludable. Subtract Line 9 from Line 4.**	10	$ 123456789.00

Enter on D-40 Schedule I, Calculation B, Line 2 (see D-40 instructions). **The exclusion may not exceed $5200 per disabled person.**

Government of the District of Columbia

2019 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer
ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKLXXXX

Taxpayer identification number (TIN)
123456789

I certify that the above taxpayer was permanently and totally disabled when the taxpayer retired. (Enter retirement date.)MM DD YYYY
00000000

Physician's first name, middle initial, last name
ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKLXXXX

Physician's address (number and street)
12345ABCDEFGHIJKLABCDEFGHXXXX

Suite number
123ABC

City
ABCDEFGHIJKLABCDEFGH

State
AB

Zip Code + 4
123456789

Physician's phone number
1234567890

Physician's signature _____

Date (MMDDYYYY)
00000000

Attach to Form D-40. See instructions.

Revised 09/19

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Enter your last name

Enter your TIN

1 9 2 4 0 0 S 2 0 0 0 1

Government of the District of Columbia

2019 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer

ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKLXXXX

Taxpayer identification number (TIN)

123456789

I certify that the above taxpayer was permanently and totally disabled when the taxpayer retired. (Enter retirement date.)

MMDD YYYY

00000000

Physician's first name, middle initial, last name

ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKLXXXX

Physician's address (number and street)

12345ABCDEFGHIJKLABCDEFGHXXXX

Suite number

123ABC

City

ABCDEFGHIJKLABCDEFGH

State

AB

Zip Code + 4

123456789

Physician's phone number

1234567890

Physician's signature

Date (MMDDYYYY)

00000000

Attach to Form D-40. See instructions.

Revised 09/19