

Government of the District of Columbia

2020 D-2440 SUB Disability Income Exclusion



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

SOFTWARE DEVELOPER USE ONLY

VENDOR ID# 9999

Taxpayer identification number (TIN)

99999999

Name as shown on Form D-40

XX

Personal information

Date of your birth (MMDDYYYY)	Date you retired (MMDDYYYY)	Name of your employer	Payor, if other than employer
99999999	99999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Date of spouses/registered partner's birth (MMDDYYYY)	Date retired (MMDDYYYY)	Name of employer	Payor, if other than employer
99999999	99999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Have you filed a physician's certification for this disability in previous years? Yes 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 2020	1 999999999.00	999999999.00
2	Multiply \$100 by the number of weeks you received disability payments in 2020. If you received pay for part of a week, see the Line 2 instructions.	2 999999999.00	999999999.00
3	Enter Line 1 or Line 2 amount, whichever is less.	3 999999999.00	999999999.00
			Total income
4	Add the amounts for you and your spouse/registered domestic partner from Line 3.	4	999999999.00

Limitation on exclusion

5	Federal adjusted gross income from Form D-40, Line 4.	Mark if loss <input checked="" type="checkbox"/>	5	999999999.00
6	Taxable social security income from Form D-40, Line 10.		6	999999999.00
7	Subtract Line 6 from Line 5.		7	999999999.00
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	999999999.00
10	Disability income payment excludable. Subtract Line 9 from Line 4.		10	999999999.00

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

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2020 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer	Taxpayer identification number (TIN)
XX	999999999

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

Physician's first name, middle initial, last name	999999999
XX	

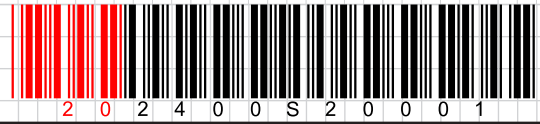
Physician's address (number and street)	Suite number
9XXXX9XXXX9XXXX9XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9XXXX

City	State	Zip Code + 4
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	999999999

Physician's phone number	Physician's signature	Date (MMDDYYYY)
9999999999		99999999

Attach to Form D-40. See instructions.

Enter your last name XXXXXXXXXXXXXXXXXXXX
Enter your TIN 999999999



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2020 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Taxpayer identification number (TIN)
999999999

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

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

99999999

Physician's address (number and street)
9XXXX9XXXX9XXXX9XXXXXXXXXXXXXXXXXXXX

Suite number
9XXXX

City
XXXXXXXXXXXXXXXXXXXX

State
XX

Zip Code + 4
99999999

Physician's phone number
999999999

Physician's signature

Date (MMDDYYYY)
99999999

Attach to Form D-40. See instructions.