

2023 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) 99999999 Date you retired (MMDDYYYY) 99999999 Name of your employer XXXXXXXXXXXXXXXXXXXXXXXXXXXX Payor, if other than employer XXXXXXXXXXXXXXXXXXXXXXXXXXXX

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

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.

Table with 4 columns: Line number, Description, You, Your spouse/registered domestic partner. Includes lines 1-4 for total amount, calculations, and total income.

Limitation on exclusion

5 Federal adjusted gross income from Form D-40, Line 4. Mark if loss X 5 99999999.00
6 Taxable social security income from Form D-40, Line 10. 6 99999999.00
7 Subtract Line 6 from Line 5. 7 99999999.00
8 Amount used to reduce the excludable disability income. 8 15000.00
9 Subtract Line 8 from Line 7. If Line 8 is more than Line 7, enter zero. 9 999999.00
10 Disability income payment excludable. Subtract Line 9 from Line 4. 10 99999999.00

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

2023 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer XXXXXXXXXXXXXXXXXXXXXXXXXXXX Taxpayer identification number (TIN) 99999999

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 XXXXXXXXXXXXXXXXXXXXXXXXXXXX 99999999

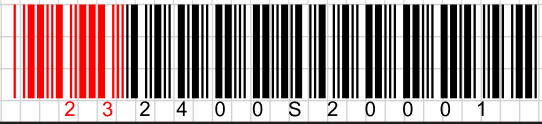
Physician's address (number and street) XXXXXXXXXXXXXXXXXXXXXXXXXXXX Suite number XXXXXX

City XXXXXXXXXXXXXXXXXXXX State XX Zip Code + 4 99999999

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

Attach to Form D-40. See instructions.

Enter your last name XXXXXXXXXXXXXXXXXXXX  
Enter your TIN 999999999



Government of the District of Columbia

# 2023 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)  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Suite number  
XXXXX

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.