Government of the District of Columbia

2021 D-2440 SUB Disability Income Exclusion

2 1 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 USE ONLY

VENDOR ID# 9999

Name as shown on Form D-40
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Taxpayer identification number (TIN)
999999999

Personal information

Dateof your birth (MMDDYYYY)	Date youretired (MMDDYYYY)	Name of your employer	Payor, if other than employer
99999999	99999999	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX

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

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 2021**	1	999999999.00	999999999.00
2	Multiply $100 by the number of weeks you received disability payments in 2021. 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 X	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.**

Government of the District of Columbia

2021 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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
99999999

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

Physician's address (number and street)
9XXXX9XXXX9XXXX9XXXXXXXXXXXXXXXXXXXX

Suite number
9XXXX

City
XXXXXXXXXXXXXXXXXXX

State
XX

Zip Code + 4
999999999

Physician's phone number
9999999999

Physician's signature

Date (MMDDYYYY)
99999999

Attach to Form D-40. See instructions.

Revised 10/2021

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Enter your last name XXXXXXXXXXXXXXXXXXXX

Enter your TIN 999999999

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

Government of the District of Columbia

2021 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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

99999999

Physician's first name, middle initial, last name

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Physician's address (number and street)

9XXXX9XXXX9XXXX9XXXXXXXXXXXXXXXXXXXX

Suite number

9XXXX

City

XXXXXXXXXXXXXXXXXXXX

State

XX

Zip Code + 4

999999999

Physician's phone number

9999999999

Physician's signature

Date (MMDDYYYY)

99999999

Attach to Form D-40. See instructions.

Revised 10/2021