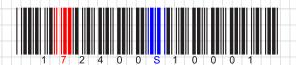
2017 D-2440 SUB Disability Income Exclusion



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

11

58 59 60

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64

Taxpayer identification number (TIN)

ABCDEFGHIJKLABCDEFGHIJKLXXXX

123456789

Per	rsonal information						
Date	e of your birth (MMDDYY) Date you retired (MMDDYY)	Name of	your 6	employer		Payor, if	other than employer
	00000 000000	ABCI	DEI	GHIJKLABCD	EFGH	ABC	DEFGHIJKLABCDEFG
	e of spouse's/domestic stered partner's birth(MMDDYY) Date retired (MMDDYY)	Name of	emplo	oyer		Payo	r, if other than employer
00	00000 000000	ABCI	DEI	FGHIJKLABCD	EFGH	ABC	DEFGHIJKLABCDEFO
	ve you filed a physician's certification for this disability	in previous	years	? X Yes X No			
If ye	es, do not file another certification. If no, you must file	the physicia	ın's c	ertification provided belo	ow.		
Inc	OME If married or registered domestic partners, use	both colum	ns.	Rol	und cents to nea	arest dol	llar. If amount is zero, leave line blank
				You			ur spouse/registered domestic partne
1	Total amount of disability payments received in 201	7 1	\$	123456789.00	0	\$	123456789.00
2	Multiply \$100 by the number of weeks you received disability payments in 2017. If you received pay for p of a week, see the Line 2 instructions.	2 art	\$	123456789.00	0	\$	5 123456789.00
3	Enter Line 1 or Line 2 amount, whichever is less.	3	\$	123456789.0	0	\$	123456789.00
			Ψ	.20.00700.0		l income	e
4	Add the amounts for you and your spouse/registered	domestic pa	rtner	from Line 3.	4	. \$	123456789.00
Lim	nitation on exclusion						
5	Federal adjusted gross income from Form D-40, Line	e 3.			5	\$	123456789.00
6	Taxable social security income from Form D-40, Line	e 9.			6	\$	123456789.00
7	Subtract Line 6 from Line 5.					7 \$	123456789.00
8	Amount used to reduce the evaluable discbility less	ma 0					- 15000.00
	Amount used to reduce the excludable disability inco			S	g	9	
9	Subtract Line 8 from Line 7. If zero or a negative nu	mber, stop n	ere. I	Do not file this form.) 4	3 123430703.00
10 Disability income payment excludable. Subtract Line 9 from Line 4.					10	\$	123456789.00
Ente	er on D-40 Schedule I, Calculation B, Line 2 (see D-40) instructions). <u>Th</u>	e exclusion may not exce	eed \$5200 per	disabled	l person.
	nment of the	an's Cer	tific	ation of Permar	ent and T	otal I	Disability
		111 3 OCI	LIIIC	ation of a cimal	icht and i	otai i	Disability
	e of disabled taxpayer				Taxpayer ident		number (TIN)
	CDEFGHIJKLABCDEFGHIJKLA				123456		M DD W/
	tify that the above taxpayer was permanently and tota ician's first name, middle initial, last name	my disabled	wner	i ille taxpayer retired. (Ei	nter retirement (00000
٩B	CDEFGHIJKLABCDEFGHIJKLA	BCDEF	Gŀ	HJKLXXXX			
Phys	ician's address (number and street)						Suite number
12	345ABCDEFGHIJKLABCDEFGH	XXXX					123ABC
City				State	Zip Code +		
	BCDEFGHIJKLABCDEFGH ician's phone number Physician's signatu	re		AB	123456	789	Date (MM DD YYYY)
	34567890	16					00000000 00000000
4	Attach to Form D-40, See instructions.		+				0000000

