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.

Name as shown on Form D-40

SOFTWARE DEVELOPER'S USE ONLY Vendor #1234

Taxpayer identification number (TIN)

999999999

Pε	ersona	al i	nfo	rm	atio	า				

Dateof your birth (MMDDYYYY) 99999999

Date youretired (MMDDYYYY) 99999999

Name of your employer  Payor, if other than employer 

Date of spouses/registered domestic Date retired(MMDDYYYY) partner's birth (MMDDYYYY)

99999999

Name of employer 

1

Payor, if other than employer

99999999

Have you filed a physician's certification for this disability in previous years? If yes, do not file another certification. If no, you must file the physician's certification provided below.

Round cents to nearest dollar. If amount is zero, leave line blank.

If married or registered domestic partners, use both columns.

You 99999999.00 Your spouse/registered domestic partner

Total amount of disability payments received in 2020

99999999.00

99999999.00

99999999.00

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.

Enter Line 1 or Line 2 amount, whichever is less.

99999999.00

99999999.00

Add the amounts for you and your spouse/registered domestic partner from Line

Subtract Line 8 from Line 7. If zero or a negative number, stop here. Do not file this form.

Total income 99999999.00

## Limitation on exclusion

3

Federal adjusted gross income from Form D-40, Line 4.

Mark if loss

99999999.00 5

Taxable social security income from Form D-40, Line 10.

6 99999999.00

Subtract Line 6 from Line 5.

99999999.00

Amount used to reduce the excludable disability income.

15000.00 99999999.00 9

10 Disability income payment excludable. Subtract Line 9 from Line 4.

99999999.00 10

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) 999999999

9xxxx9xxxx9xxxx9xxxxxxxxxxxxxxx

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

Physician's address (number and street)

Suite number 9XXXX

State Zip Code + 4

XXXXXXXXXXXXXXXXXXXXXX Physician's signature 99999999

Physician's phone number 999999999

59

60

XX

Attach to Form D-40. See instructions

Date (MMDDYYYY) 99999999

