

Government of the District of Columbia

# 2015 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

Your social security number

ABCDEFGHIJKLMNABCDEFGHIJKLMNABCDEFGHIJKLMNXXXX

123456789

## Personal information

Date of your birth (MMDDYY)	Date you retired (MMDDYY)	Name of your employer	Payor, if other than employer
000000	000000	ABCDEFGHIJKLMNABCDEFGHIJKLMN	ABCDEFGHIJKLMNABCDEFGHIJKLMN

Date of spouse's/domestic registered partner's birth(MMDDYY)	Date retired (MMDDYY)	Name of employer	Payor, if other than employer
000000	000000	ABCDEFGHIJKLMNABCDEFGHIJKLMN	ABCDEFGHIJKLMNABCDEFGHIJKLMN

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 the nearest dollar. If amount is zero, leave the line blank.

		You	Your spouse/registered domestic partner
1	Total amount of disability payments received in 2015	1 \$ 123456789.00	\$ 123456789.00
2	Multiply \$100 by the number of weeks you received disability payments in 2015. If you received pay for part of a week, see the Line 2 instructions.	2 \$ 123456789.00	\$ 123456789.00
3	Enter Line 1 or Line 2 amount, whichever is less.	3 \$ 123456789.00	\$ 123456789.00
4	Add the amounts for you and your spouse/registered domestic partner from Line 3.		Total income 4 \$ 123456789.00

## Limitation on exclusion

5	Federal adjusted gross income from Form D-40, Line 3.	5 \$ 123456789.00
6	Taxable social security income from Form D-40, Line 9.	6 \$ 123456789.00
7	Subtract Line 6 from Line 5.	7 \$ 123456789.00
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 \$ 123456789.00
10	Disability income payment excludable. Subtract Line 9 from Line 4.	10 \$ 123456789.00

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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# 2015 Physician's Certification of Permanent and Total Disability

Name of disabled taxpayer	Social security number
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ABCDEFGHIJKLMNABCDEFGHIJKLMNABCDEFGHIJKLMNXXXX 123456789

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

Physician's first name, middle initial, last name 000000

ABCDEFGHIJKLMNABCDEFGHIJKLMNABCDEFGHIJKLMNXXXX

Physician's address (number and street) Suite number  
12345ABCDEFGHIJKLMNABCDEFGHIJKLMNXXXX 123ABC

City State Zip Code + 4

ABCDEFGHIJKLMNABCDEFGHIJKLMN AB 123456789

Physician's phone number Physician's signature Date (MM DD YYYY)  
1234567890 00000000

Attach to Form D-40. See instructions.