

2004 D-2440 SUB Disability Income Exclusion

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OFFICIAL USE ONLY

Leave lines blank that do not apply.

NAME AS SHOWN ON FORM D-40 ABCDEFGHIJKLMNOPQRSTUVWXYZ YOUR SOCIAL SECURITY NUMBER 123456789

Personal information

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

Date of spouse's birth (MMDDYY) Date spouse retired (MMDDYY) Name of spouse's employer Payor, if other than employer MMDDYY MMDDYY ABCDEFGHIJKLMNOPQRSTUVWXYZ ABCDEFGHIJKLMNOPQRSTUVWXYZ

Have you filed a physician's certification for this disability in previous years? X YES X NO

If yes you do not have to file another certification. If no, you must file the physician's certification below.

Income table with columns for You and Your spouse. Rows include Total amount of disability payments received in 2004, calculations for weekly payments, and Total Income.

Limitation on exclusion

Limitation on exclusion table with 10 rows detailing federal adjusted gross income, taxable social security income, and the final disability income exclusion amount.

2004 Physician's Certification of Permanent and Total Disability

Physician's Certification form fields including Name of disabled, Social security number, Physician's name, address, city, state, zip, phone number, and signature.

Attach to Form D-40. See instructions.