Government of the District of Columbia

2005 D-2440 SUB Disability Income Exclusion

0 5 2 4 0 0 2 1 0 0 0 0

OFFICIAL USE ONLY

Leave lines blank that do not apply.

NAME AS SHOWN ON FORM D-40 ABCDEFGHIJKLABCDEFGH 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	ABCDEFGHIJKLABCDEFGH	ABCDEFGHIJKLABCDEFGH

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

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

If married, complete both columns. Round cents to the nearest dollar. If amount is zero, leave the line blank.

		You	Your spouse
1	Total amount of disability payments received in 2005.	1 $ 123456789.**00**	$ 123456789.**00**
2	Multiply $100 by the number of weeks you claimed disability payments in 2005. If you received pay for part of a week, see instructions.	2 $ 123456789.**00**	$ 123456789.**00**
3	Enter Line 1 or Line 2 amount, whichever is less.	3 $ 123456789.**00**	$ 123456789.**00**
			Total Income
4	*Add the Line 3 amounts for you and your spouse.*		4 $ 123456789.**00**

Limitation on exclusion

5	Federal adjusted gross income *from Form D-40, Line 12.*	5 $ 123456789.**00**
6	Taxable social security income *from Form D-40 instructions, Calculation A, Line d.*	6 $ 123456789.**00**
7	Subtract Line 6 from Line 5.	7 $ 123456789.**00**
8	Minus: amount used to reduce disability income	8 - $15,000.00
9	Subtract Line 8 from Line 7. If zero or a negative number, stop here.	9 $ 123456789.**00**
10	Disability income exclusion *Subtract Line 9 from Line 4.* *Enter in Calculation A, Line e. (see Form D-40 instructions)* This exclusion may not exceed $5200	10 $ 123456789.**00**

2005 Physicianís Certification of Permanent and Total Disability

Name of disabled: ABCDEFGHIJKLABCDEFGH

Social security number: 123456789

I certify that the above taxpayer was permanently and totally disabled on the date the taxpayer retired (Enter the date retired) MMDDYY

Physician's first name, middle initial, last name: ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKL

Physician's address (number and street): 12345ABCDEFGHIJKLABCDEFGH

Suite/apartment number: 12ABC

City: ABCDEFGHIJKLABCDEFGH

State: AB

Zip: 123456789

Physician's phone number: 1234567890

Physician's Sigtanure: _____

Date: _____

Attach to Form D-40. See instructions.

Rev 10/05