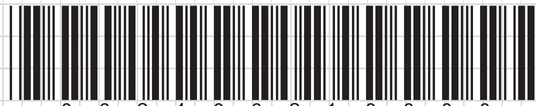
Government of the District of Columbia

2006 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 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 2006.	1	$ 123456789.00	$ 123456789.00
2	Multiply $100 by the number of weeks you claimed disability payments in 2006. 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
4	*Add the Line 3 amounts for you and your spouse.*			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 10.*	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 the result is zero or a negative amount, leave this line blank.	9	$ 123456789.00
10	Disability income exclusion *Subtract Line 9 from Line 4.* *Enter in D-40 Schedule I, Calculation B, Line 2. (see Form D-40 instructions)* This exclusion may not exceed $5200	10	$ 123456789.00

2006 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

Zipcode + 4: 123456789

Physician's phone number: 1234567890

Physician's Sigtanure ______________________

Date __________

Attach to Form D-40. See instructions.

Rev 2/07