



Office of the Tax Commissioner

Employer Application for Disabled Person Exemption

SECTION I EMPLOYER DECLARATION

EMPLOYER ACCOUNT NUMBER:
BUSINESS NAME:
REGISTERED NAME:
MAILING ADDRESS:

ELIGIBLE EMPLOYEE

Table with 6 columns: Employee Name, Job Title, Date of Birth, Social Insurance #, Employment Start Date, Quarterly Remuneration

TERMS AND CONDITIONS

- (1) Eligible employees are those hired with permanent physical or mental disabilities.
(2) Approved taxpayers can pay the Payroll Tax rate of 0% on the Employer Portion of remuneration paid to eligible disabled employees effective April 1st 2018.
(3) Further information may be requested at the discretion of the Office of the Tax Commissioner.
(4) The reduced tax rate will not be given with respect to Self-Employed/Deemed Employees.
(5) Employers must not be in arrears upon application and must also remain current with payroll tax payments to benefit from the reduced rate.
(6) The employment of the disabled employee must not involve payroll tax avoidance arrangements.

I understand that the failure to abide by all the terms and conditions will render this relief null and void and that tax plus applicable penalties at the standard rate will be levied by the Office of the Tax Commissioner in accordance with the Taxes Management Act 1976. Non-compliance may also be considered an offence of Criminal Tax Evasion which is an indictable offence per Section 37 of the Taxes Management Act 1976.

Employer Signature: Date:
Print name: Title:
Contact #: Email:

SECTION II EMPLOYEE DECLARATION

I hereby give permission for the details regarding my disability to be disclosed to the Office of the Tax Commissioner for the purposes of Employer Portion Payroll Tax relief. I understand that the Employee Portion of tax remains due.

Employee Signature: Date:
Contact #: Email:

SECTION III PHYSICIAN DECLARATION

Briefly describe the disabled persons condition below (attach additional documents where required).

I verify that the above information is true and correct based on my evaluation of this patient. I attest that in my professional opinion the above employee is permanently disabled in accordance with section 9A of the Payroll Tax Act 1995 which impacts the ability to find and retain employment.

Signature of Physician: Date:
Print Name: Credentials (eg MD):
Contact #: Email:

For Official Use Only

Is Taxpayer Current? Yes No
Approved? Yes No
Reviewer Date

Empty rectangular box for official use.