



Mandatory e-Pay Requirement—Waiver Request

STOP. This form is used to request a waiver of the mandatory e-pay requirement. Do not use this form to request an abatement of a Mandatory e-Pay Penalty. To request an abatement of the penalty, use FTB 2917, *Reasonable Cause—Individual and Fiduciary Claim for Refund*. Go to ftb.ca.gov/Forms and search for **2917**.

Taxpayers who are required to pay electronically may request a waiver of the mandatory e-pay requirement if **one or more** of the following exceptions apply:

- You have not made an estimated tax or extension payment in excess of \$20,000 for the previous taxable year and your tax liability did not exceed \$80,000 for the previous taxable year.
- Your previous tax liability or the amounts you previously paid, causing you to meet the mandatory e-pay requirement, are not representative of your future payments or tax liability.
- You are requesting a permanent waiver due to a physical or mental impairment. If you have a permanent physical or mental impairment that prevents you from using a computer, include the Physician Affidavit of Permanent Physical or Mental Impairment. The affidavit must be completed, signed, and included with your waiver request.

How to Complete This Form

If you meet one of the waiver request exceptions, complete this form, sign, and include any required documents (if applicable), then follow the mailing instructions under **Where to Send**. If you file a joint tax return, you must also include the information for your spouse or registered domestic partner (RDP), including their social security number (SSN) or individual taxpayer identification number (ITIN).

Important Information

You must continue to pay electronically until we notify you in writing that we approved your waiver request. Payments made by other means will result in a penalty of one percent of the amount paid unless you show that your failure to pay electronically was due to reasonable cause and not willful neglect (California Revenue and Taxation Code Section 19011.5).

Personal Information

Complete the following information. If you file jointly, complete the information for **both** you and your spouse/RDP.

Taxpayer's Name		SSN or ITIN	
If Joint Tax Return, Spouse's/RDP's Name		Spouse's/RDP's SSN or ITIN	
Address (number and street or PO box)		Apt. No./Ste. No.	PMB/Private Mailbox
City		State	ZIP Code
Foreign Country Name	Foreign Province/State/County	Foreign Postal Code	

Mandatory e-Pay Requirement—Waiver Request Reason

Select one of the following options that best fits your situation and provide an explanation (if applicable), then go to **Signature Authorization**.

- ☐ I request a waiver from the mandatory e-pay requirement because I have not made an estimated tax or extension payment in excess of \$20,000 for the previous taxable year and my tax liability did not exceed \$80,000 for the previous taxable year (previous year from the date signed on this form).
- ☐ I request a waiver from the mandatory e-pay requirement because my previous tax liability, or the amounts I previously paid, causing me to meet the mandatory e-pay requirement, are not representative of my future payments or tax liability.
- ☐ **Permanent Physical or Mental Impairment—Permanent Waiver Request**
I request a waiver of the mandatory e-pay requirement because of a permanent physical or mental impairment. I understand I must attach a completed and signed **Physician Affidavit of Permanent Physical or Mental Impairment** to this form. If I file jointly, I understand that my spouse/RDP must also complete their own FTB 4107 PC and attach their own **Physician Affidavit of Permanent Physical or Mental Impairment** to be permanently waived of the requirement. If the Physician Affidavit of Permanent Physical or Mental Impairment is incomplete or not attached to FTB 4107 PC, *Mandatory e-Pay Requirement—Waiver Request*, I understand FTB will not approve the request.

Signature Authorization

I hereby certify under penalty of perjury under the laws of the state of California, that all information supplied on this form including any attachment is true, correct, and complete to the best of my knowledge and ability.

Sign and date in the following applicable fields. If you file jointly, **both** spouses/RDPs must sign this form or be signed by each taxpayer's power of attorney on file with the Franchise Tax Board.

Taxpayer's Signature X	Date
Spouse's/RDP's Signature X	Date
Power of Attorney's (POA) Signature X	Date

Where to Send

Mail your completed, signed, and dated waiver request to the following address. If requesting a permanent waiver, include your completed **Physician Affidavit of Permanent Physical or Mental Impairment** form and any extra sheets of paper with explanation, if necessary.

Mail: STATE OF CALIFORNIA
FRANCHISE TAX BOARD
PO BOX 942840
SACRAMENTO CA 94240-0040

Franchise Tax Board Privacy Notice

To learn about your privacy rights, how we may use your information, and consequences if you do not provide information we request, go to **ftb.ca.gov/Forms** and search for **1131**. To request this notice by mail, call 800.338.0505 and enter form code **948** when instructed.

Connect With Us

Web: **ftb.ca.gov**
Phone: 800.852.5711 from 8 a.m. to 5 p.m. weekdays, except state holidays
916.845.6500 from outside the United States
TTY/TDD: 800.822.6268 for persons with hearing or speech impairments



Physician Affidavit of Permanent Physical or Mental Impairment

Taxpayer Instructions

Have your physician complete, sign, and date this affidavit of your permanent physical or mental impairment. Send in the **original** affidavit signed by your physician. Keep a copy for your records.

Physician Instructions

Complete the following information about your patient and their physical or mental condition. Sign and date.

Patient Information

Patient's Name	SSN or ITIN		
Address (number and street or PO box)	Apt. No./Ste. No.	PMB/Private Mailbox	
City	State	ZIP Code	

Physician Affidavit of Permanent Physical or Mental Impairment

Physician's Name	Medical License Number		
Physician's Business Address (number and street or PO box)	Ste. No.	PMB/Private Mailbox	
City	State	ZIP Code	

1. Provide a description of the patient's permanent physical or mental impairment. (If you need additional space, attach a separate piece of paper.)

2. In your medical opinion, does the permanent impairment prevent the patient from using a computer? ☐ Yes ☐ No
If yes, list the date the patient became permanently mentally or physically impaired, and unable to use a computer.

Signature Authorization

The patient named in this affidavit is/was under my care. I completed this physician affidavit and I hereby certify under penalty of perjury under the laws of the state of California, that all information supplied on this form including any attachment is true, correct, and complete to the best of my knowledge and ability.

Physician's Signature X	Date
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