MARYLAND FORM **502B**

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)

24502B099

2024

Print Using Blue or Black Ink Only

Your Social Security Number ____ Spouse's Social Security Number ____

Your First Name ____ MI ____

Your Last Name ____

Spouse's First Name ____ MI ____

Spouse's Last Name ____

Summary

1. Enter the total number checked below for Regular dependents (4) . . . . ▶ 1. ____
2. Enter the total number checked below for dependents 65 or over (5) . . . . ▶ 2. ____
3. Total dependent exemptions (Add lines 1 and 2 and enter the total here and on line (C) of the Exemptions area of Form 502, 505 or 515.) . . . . 3. ____

Dependents (If a dependent listed below is age 65 or over, check both 4 and 5.)

▶ 1. First Name ____ MI ____ ▶ Last Name ____
▶ 2. Social Security Number ____ 3. Relationship ____ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ____
You must provide the date of birth for the individual listed.

▶ 1. First Name ____ MI ____ ▶ Last Name ____
▶ 2. Social Security Number ____ 3. Relationship ____ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ____
You must provide the date of birth for the individual listed.

▶ 1. First Name ____ MI ____ ▶ Last Name ____
▶ 2. Social Security Number ____ 3. Relationship ____ 4. Regular ☐ 5. 65 or over ☐
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DOB (MM/DD/YYYY) ▶ ____
You must provide the date of birth for the individual listed.

▶ 1. First Name ____ MI ____ ▶ Last Name ____
▶ 2. Social Security Number ____ 3. Relationship ____ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ____
You must provide the date of birth for the individual listed.

MARYLAND FORM **502B** **DEPENDENTS' INFORMATION** (Attach to Forms 502, 505 or 515.)

24502B199

Name ______________________ SSN ______________

▶ 1. First Name ______ MI ___ ▶ Last Name ______
▶ 2. Social Security Number ______ 3. Relationship ______ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______
You must provide the date of birth for the individual listed.

▶ 1. First Name ______ MI ___ ▶ Last Name ______
▶ 2. Social Security Number ______ 3. Relationship ______ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______
You must provide the date of birth for the individual listed.

▶ 1. First Name ______ MI ___ ▶ Last Name ______
▶ 2. Social Security Number ______ 3. Relationship ______ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______
You must provide the date of birth for the individual listed.

▶ 1. First Name ______ MI ___ ▶ Last Name ______
▶ 2. Social Security Number ______ 3. Relationship ______ 4. Regular ☐ 5. 65 or over ☐
Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______
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Check here ▶ ☐ if this dependent does not have health care coverage
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