MARYLAND FORM 502B

Dependents' Information
(Attach to Form 502, 505 or 515.)

19502B099

2019

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 _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

Check here ▶ ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ▶ _____

FINAL 10/15/2019

COM/RAD-026

MARYLAND FORM
502B

Dependents' Information
(Attach to Form 502, 505 or 515.)

19502B199

2019
Page 2

NAME _____ SSN _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

► 1.
First Name _____ MI __ ► Last Name _____

Social Security Number   Relationship   Regular   65 or over
► 2. _____ 3. _____ 4. __ 5. __

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

COM/RAD-026