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

19502B049

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

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

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

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

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

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

MARYLAND FORM **502B**

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

19502B149

NAME ______________________ SSN ______________

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

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

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

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

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

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