MARYLAND FORM 502B

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



Your Social Security Number Spouse's Social Security Number Ink Only MI Your First Name Black Your Last Name Blue Spouse's First Name MI Spouse's Last Name Summary 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 Dependents (If a dependent listed below is age 65 or over, check both 4 and 5.) First Name МТ Last Name **1**. Check here if this dependent does not have health care coverage Social Security Number Regular Relationship 65 or over 2. 4. _ 5. __ DOB (MM/DD/YYYY) ▶ First Name ΜI Last Name Check here ► **▶** 1. if this dependent does not have health care coverage Relationship Social Security Number Regular 65 or over **2**. 3. DOB (MM/DD/YYYY) ▶ First Name ΜI Last Name if this dependent does Check here **1**. not have health care coverage Social Security Number Relationship Regular 65 or over DOB (MM/DD/YYYY) ▶ _ **2**. 3. First Name ΜI Last Name Check here if this dependent does **1**. not have health care coverage Social Security Number Regular 65 or over Relationship DOB (MM/DD/YYYY) ▶ **2**. 4. __ First Name ΜI Last Name if this dependent does **▶** 1. Check here not have health care coverage 65 or over Social Security Number Relationship Regular DOB (MM/DD/YYYY) ▶ **2**. First Name ΜI Last Name Check here if this dependent does **▶** 1. not have health care coverage Social Security Number Relationship Regular 65 or over DOB (MM/DD/YYYY) ▶ 4. __ 5. __ **2**.

MARYLAND FORM 502B

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



Page 2

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

4. _

5. __

DOB (MM/DD/YYYY) ▶ ___

2. _