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 ____________ 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) ▶ ____________

Dependents' Information

(Attach to Form 502, 505 or 515.)

19502B149

NAME ________________ SSN ________________

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. ________	3. ________		4. ☐	5. ☐		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. ________	3. ________		4. ☐	5. ☐		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. ________	3. ________		4. ☐	5. ☐		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. ________	3. ________		4. ☐	5. ☐		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. ________	3. ________		4. ☐	5. ☐		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. ________	3. ________		4. ☐	5. ☐		DOB (MM/DD/YYYY) ▶ ________