FORM **502B**

Black Ink

Blue or

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)



Your Social Security Number Spouse's Social Security Number Your First Name ΜI Your Last Name Spouse's First Name MT Spouse's Last Name Summary 1. Enter the total number checked below for Regular dependents (4) 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 Last Name **1**. Check here \perp if this dependent does Social Security Number Relationship Regular 65 or over not have health care coverage 2. 3. 5. DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed. МТ Last Name First Name **1**. Check here if this dependent does Social Security Number Relationship 65 or over not have health care coverage **2**. 5. DOB (MM/DD/YYYY) ▶ _ You must provide the date of birth for the individual listed. Last Name **1**. Check here if this dependent does Social Security Number Relationship Regular 65 or over not have health care coverage 5. **2**. DOB (MM/DD/YYYY) ▶ You must provide the date of birth for the individual listed. First Name ΜI Last Name **1**. if this dependent does Check here Social Security Number Relationship 65 or over not have health care coverage Regular 5. DOB (MM/DD/YYYY) ▶ _ You must provide the date of birth for the individual listed. First Name ΜI Last Name **1**. Check here if this dependent does not have health care coverage Regular Social Security Number Relationship 65 or over 5. DOB (MM/DD/YYYY) ▶ **2**. 3. You must provide the date of birth for the individual listed.

MARYLAND FORM **502B**

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)



2024

Page 2

Name			SSN			
► 1. ► 2.	Social Security Number	MI Nelationship 3.	Last Name	Regular 4.	65 or over 5	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. ▶ 2.	Social Security Number	Relationship 3.	Last Name	Regular 4.	65 or over 5	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. ► 2.	Social Security Number	MI Nelationship 3.	Last Name	Regular 4.	65 or over 5	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. ► 2.	First Name Social Security Number	MI Nelationship 3.	Last Name	Regular 4.	65 or over 5	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. ► 2.	First Name Social Security Number	MI Relationship 3.	Last Name	Regular 4.	65 or over 5.	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.
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