MARYLAND FORM **502B**

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)

24502B099

2024

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 ____________ 4. Regular ☐ 5. 65 or over ☐
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. First Name ____________ MI ____ ▶ Last Name ____________
▶ 2. Social Security Number ____________ 3. Relationship ____________ 4. Regular ☐ 5. 65 or over ☐
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Name ______________________ SSN ____________

▶ 1. First Name ______ MI ___ ▶ Last Name ______
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