2021

MARYLAND Dependents' Information FORM (Attach to Form 502, 505 **502B** or 515.) Your Social Security Number Spouse's Social Security Number Black Ink Only MI Your First Name Your Last Name Blue Spouse's First Name 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.≥ 2.	Social Security Number	Relationship 3.	Regular 4	65 or over 5	Check here if this dependent does not have health care coverage DOB (MM/DD/YYYY)
▶ 1.▶ 2.	First Name Social Security Number	MI Last Na Relationship 3.	Regular 4.	65 or over 5	Check here if this dependent does not have health care coverage DOB (MM/DD/YYYY) □
▶ 1.▶ 2.	First Name Social Security Number	MI Last Na Relationship 3.	Regular 4	65 or over 5	Check here if this dependent does not have health care coverage DOB (MM/DD/YYYY) □
▶ 1.▶ 2.	First Name Social Security Number	MI Last Na Relationship 3.	Regular	65 or over 5	Check here ☐ if this dependent does not have health care coverage DOB (MM/DD/YYYY) ☐
▶ 1. ▶ 2	First Name Social Security Number	MI Last Na Relationship	nme Regular 4	65 or over	Check here if this dependent does not have health care coverage DOB (MM/DD/YYYY) DOB (MM/DD/YYYY)

Regular

4. __

65 or over

5. __

Check here

DOB (MM/DD/YYYY) ▶

not have health care coverage

if this dependent does

Social Security Number

First Name

1.

ΜI

Relationship

Last Name

MARYLAND FORM 502B

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



2021

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

5. __

DOB (MM/DD/YYYY) ▶ _

▶ 2.