MARYLAND FORM **502B**

Dependents' Information

(Attach to Form 502, 505 or 515.)

22502B099

2022

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 ________ Regular 4. __ 65 or over 5. __ 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 ________ Regular 4. __ 65 or over 5. __ DOB (MM/DD/YYYY) ▶ ________

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▶ 2. Social Security Number ________ 3. Relationship ________ Regular 4. __ 65 or over 5. __ DOB (MM/DD/YYYY) ▶ ________

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

NAME ______________________ SSN ______________

▶ 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) ▶ ______

▶ 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) ▶ ______

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▶ 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) ▶ ______

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Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______

▶ 1. First Name ______ MI __ ▶ Last Name ______
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Check here ▶ ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ▶ ______