MARYLAND FORM **502B**

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)

24502B099

2024

Your Social Security Number ______ Spouse's Social Security Number ______

Print Using Blue or Black Ink Only

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 ☐

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 ☐

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 ☐

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 ☐

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.

DEPENDENTS' INFORMATION

(Attach to Forms 502, 505 or 515.)

24502B199

Name ______________________ SSN ______________

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.

First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 5. ☐

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ __________

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First Name | MI | Last Name
▶ 1. ______________ ____ ▶ ______________

Social Security Number | Relationship | Regular | 65 or over
▶ 2. __________ 3. ______________ 4. ☐ 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.