

DEPENDENTS' INFORMATION (Attach to Forms 502, 505 or 515.)



Your So	ocial Security Number	Spouse's Soci	al Security Number			
Your Fi	rst Name		MI			
Your La	ast Name					
Spouse	's First Name					
Spouse	e's Last Name					
Sumn	<b>nary</b> er the total number cheo	ked below for	Regular depender	nts (4)		▶1
3. Tot	er the total number cheor al dependent exemptions emptions area of Form 5	s (Add lines 1	and 2 and enter th	he total here a	and on line (C)	of the
Depe	ndents (If a dependent	listed below is	age 65 or over, o	check both 4 a	and 5.)	
▶ 1.	First Name	►	Last Name	<u></u> )		Check here  if this dependent does
▶ 2.	Social Security Number	Relationship 3.		Regular 4.	65 or over 5.	not have health care coverage DOB (MM/DD/YYYY)
▶ 1.	First Name	MI	Last Name			Check here
▶ 2.	Social Security Number	Relationship		Regular	65 or over	not have health care coverage DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed.
▶ 1.	First Name	MÎ	Last Name			Check here
▶ 2.	Social Security Number	Relationship		Regular	65 or over	
▶ 1.	First Name	MI	Last Name			Check here
▶ 2.	Social Security Number	Relationship		Regular4.	Regular     65 or over     not have health care coverage       .     .     .       DOB (MM/DD/YYYY) ▶	not have health care coverage
▶ 1.	First Name	MI	Last Name			Check here  if this dependent does
	Social Security Number	Relationship 3.		Regular	65 or over 5.	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.)



\_ SSN Name First Name MI Last Name Check here ► if this dependent does ▶ 1. not have health care coverage Social Security Number Regular Relationship 65 or over DOB (MM/DD/YYYY) 5. 2. 3. 4 You must provide the date of birth for the individual listed. First Name MI Last Name ▶ 1. if this dependent does Check here not have health care coverage Social Security Number Relationship Regular 65 or over ▶ 2. 3. 4. 5. DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed. First Name MI Last Name ▶ 1. Check here if this dependent does Social Security Number Relationship 65 or over no<mark>t</mark> have health care coverage Regular 2. 3. 4. 5. DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed. First Name MI Last Name if this dependent does ▶ 1. Check here not have health care coverage Social Security Number Relationship Regular 65 or over 5. 2. 3. 4. DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed. First Name MI Last Name Check here if this dependent does ▶ 1. not have health care coverage Social Security Number Relationship Regular 65 or over 5. 3. 4. DOB (MM/DD/YYYY) 2. \_ You must provide the date of birth for the individual listed. First Name MI Last Name ▶ 1. Check here if this dependent does not have health care coverage Relationship Social Security Number Regular 65 or over 5. 2. \_ 3. 4. DOB (MM/DD/YYYY) You must provide the date of birth for the individual listed. First Name MI Last Name ▶ 1. Check here if this dependent does Social Security Number Relationship Regular 65 or over not have health care coverage 4. 5.l DOB (MM/DD/YYYY) ▶ \_ 2. 3. \_ You must provide the date of birth for the individual listed.