## MARYLAND FORM **502B**

## **Dependents' Information** (Attach to Forms 502, 505 or 515.)

Your	Social Security Number	rity Number				
Ink Only Your	First Name		MI			
Print Using Blue or Black Ink Only	Last Name					
Print Using   	use's First Name		MI			
Sno	use's Last Name					
	nmary					
2. E 3. T	nter the total number of otal dependent exemp	checked below for tions (Add lines 1	dependents 65 and 2 and ente	or over (5) er the total here	and on line (C	▶ 1
	pendents (If a depend		-			
<b>&gt;</b> :	First Name	MI	Last Name			Check here if this dependent does not have health care coverage
<b>&gt;</b> :	Social Security Number 2.	Relationship  3.		Regular 4	65 or over <b>5.</b>	DOB (MM/DD/YYYY)
	E. I.N.	MT				
<b>&gt;</b> :	First Name  1.  Social Security Number	MI Relationship	Last Name	Regular	 65 or over	Check here if this dependent does not have health care coverage
<b>&gt;</b> :	•	3		4	5	DOB (MM/DD/YYYY)
<b>&gt;</b> :	First Name	MI <b>&gt;</b>	Last Name			Check here if this dependent does
<b>&gt;</b> :	Social Security Number 2.	Relationship 3.		Regular 4	65 or over <b>5.</b>	not have health care coverage  DOB (MM/DD/YYYY)
<b>&gt;</b>	First Name 1.	MI	Last Name			Check here ▶ if this dependent does
<b>&gt;</b> :	Social Security Number	Relationship 3.		Regular	65 or over 5	not have health care coverage  DOB (MM/DD/YYYY) ▶
<b>&gt;</b>	First Name	MI <b>•</b>	Last Name			Check here if this dependent does
<b>&gt;</b> :	Social Security Number 2.	Relationship 3.		Regular 4	65 or over 5	not have health care coverage  DOB (MM/DD/YYYY) ▶
<b>•</b>	First Name 1.	MI	Last Name			Check here ▶ if this dependent does
	Social Security Number	Relationship		Regular 4.	65 or over	not have health care coverage  DOB (MM/DD/YYYY)

## MARYLAND FORM **502B**

## **Dependents' Information** (Attach to Forms 502, 505 or 515.)

Name			SSN			
<b>1</b> .	First Name	MI	Last Name			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) ▶
<b>1</b> .	First Name	MI -	Last Name			Check here ▶ if this dependent does
<b>▶</b> 2.	Social Security Number	Relationship 3.		Regular 4.	65 or over 5	not have health care coverage  DOB (MM/DD/YYYY) ▶
<b>▶</b> 1.	First Name	MI 🕨	Last Name			Check here ▶ if this dependent does
<b>▶</b> 2.	Social Security Number	Relationship  3.		Regular 4	65 or over <b>5.</b>	not have health care coverage  DOB (MM/DD/YYYY) ▶
	First Name	MI	Last Name			
<b>▶</b> 1.	Social Security Number	Relationship	Lust Name	Regular	65 or over	Check here  if this dependent does not have health care coverage
<b>▶</b> 2.				4		DOB (MM/DD/YYYY) ▶
<b>▶</b> 1.	First Name	MI <b>&gt;</b>	Last Name			Check here ▶ if this dependent does
	Social Security Number	Relationship		Regular	65 or over	not have health care coverage
<b>2</b> .		3		4	5	DOB (MM/DD/YYYY)
<b>▶</b> 1.	First Name	MI	Last Name			Check here if this dependent does
	Social Security Number	Relationship		Regular	65 or over	not have health care coverage
<b>2</b> .		3		4	5	DOB (MM/DD/YYYY)