MARYLAND FORM **502B**

Dependents' Information

(Attach to Forms 502, 505 or 515.)

23502B049

2023

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) ▶ ______

▶ 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) ▶ ______

▶ 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) ▶ ______

▶ 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) ▶ ______

MARYLAND FORM

502B

Dependents' Information

(Attach to Forms 502, 505 or 515.)

23502B149

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) ▶ ______

▶ 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) ▶ ______

▶ 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) ▶ ______