2024

## FORM **502B**

Print Using Blue or Black Ink Only

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



Your So	ocial Security Number	Spouse's Social	Security Number			
Your Fi	rst Name		MI			
Your La	ast Name					
Spouse's First Name		MI				
Spouse	e's Last Name					
Sumn	nary					
1. Ent	er the total number che	ecked below for R	egular dependent	ts (4)		▶1
	er the total number che al dependent exemption					
						3
Dene	ndents (If a dependent	t listed helow is a	age 65 or over ch	neck hoth 4 a	nd 5 )	
- СРС	First Name		st Name			
<b>▶</b> 1.		• _				Check here ▶ ☐ if this dependent does
<b>▶</b> 2.	Social Security Number	Relationship		Regular 4.	65 or over 5.	not have health care coverage  DOB (MM/DD/YYYY)
		J			J	You must provide the date of birth for the individual listed.
	First Name	MI La	st Name			
<b>▶</b> 1.		▶ _				Check here ▶ ☐ if this dependent does
<b>▶</b> 2.	Social Security Number	Relationship 3.		Regular	65 or over 5.	not have health care coverage
2.		J			J	DOB (MM/DD/YYYY)  You must provide the date of birth for the individual listed.
	First Name	MI La	st Name			
<b>1</b> .		\	st name			Check here ▶ ☐ if this dependent does
• 1	Social Security Number	Relationship		Regular	65 or over	not have health care coverage
<b>▶</b> 2.		3		4	5	DOB (MM/DD/YYYY)   You must provide the date of birth for the individual listed.
<b>1</b> .	First Name	MI La	st Name			Check here   if this dependent does
	Social Security Number	Relationship		Regular	65 or over	not have health care coverage
<b>▶</b> 2.		3		4	5	DOB (MM/DD/YYYY)   You must provide the date of birth for the individual listed.
	First Name	MI La	st Name			
<b>▶</b> 1.	Social Security Number	Relationship		Regular	 65 or over	Check here ► if this dependent does not have health care coverage
<b>2</b> .		3		_ 4.	5.	DOB (MM/DD/YYYY) ▶
						You must provide the date of birth for the individual listed.

## MARYLAND FORM **502B**

## **DEPENDENTS' INFORMATION**

(Attach to Forms 502, 505 or 515.)



2024 Page 2

Name				SSN		-	
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name Social Security Number		tionship	Last Name	Regular 4.	65 or over 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.
▶ 1. ▶ 2.	First Name  Social Security Number	Rela	I butionship	Last Name	Regular 4.	65 or over 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.
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name Social Security Number		tionship	Last Name	Regular 4.	65 or over 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.
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name Social Security Number		tionship	Last Name	Regular 4	65 or over 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.
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name  Social Security Number		tionship	Last Name	Regular 4	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.
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name  Social Security Number		tionship	Last Name	Regular 4.	65 or over 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.
<ul><li>▶ 1.</li><li>▶ 2.</li></ul>	First Name Social Security Number		tionship	Last Name	Regular 4. 🔲	65 or over 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.