



24502B049

Your Social Security Number

Spouse's Social Security Number

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	Check here <input type="checkbox"/> if this dependent does not have health care coverage	
2.	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) <input type="checkbox"/>
3.					You must provide the date of birth for the individual listed.

1.	First Name	MI	Last Name	Check here <input type="checkbox"/> if this dependent does not have health care coverage	
2.	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) <input type="checkbox"/>
3.					You must provide the date of birth for the individual listed.

1.	First Name	MI	Last Name	Check here <input type="checkbox"/> if this dependent does not have health care coverage	
2.	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) <input type="checkbox"/>
3.					You must provide the date of birth for the individual listed.

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2.	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) <input type="checkbox"/>
3.					You must provide the date of birth for the individual listed.

1.	First Name	MI	Last Name	Check here <input type="checkbox"/> if this dependent does not have health care coverage	
2.	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) <input type="checkbox"/>
3.					You must provide the date of birth for the individual listed.



24502B149

Name _____ SSN _____

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

▶ 1.	First Name _____	MI _____	▶	Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage	
	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
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	Social Security Number _____	Relationship _____				
▶ 2.	_____	3.	_____	4. <input type="checkbox"/> Regular	5. <input type="checkbox"/> 65 or over	DOB (MM/DD/YYYY) ▶ _____
						<i>You must provide the date of birth for the individual listed.</i>

