MARYLAND FORM 502B

Dependents' Information
(Attach to Form 502, 505 or 515.)

20502B049

2020

Print Using Blue or Black Ink Only

▶ _____ 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 ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____				Check here ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____				Check here ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____				Check here ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____				Check here ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____				Check here ▶ ☐ if this dependent does not have health care coverage
Social Security Number	Relationship	Regular	65 or over	
▶ 2. _____	3. _____	4. __	5. __	DOB (MM/DD/YYYY) ▶ _____

COM/RAD-026

MARYLAND FORM **502B** **Dependents' Information** (Attach to Form 502, 505 or 515.)

20502B149

2020

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NAME _____ SSN _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Check here ▶ ☐ if this dependent does not have health care coverage

▶ 2. Social Security Number _____ 3. Relationship _____ Regular 4. __ 65 or over 5. __

DOB (MM/DD/YYYY) ▶ _____

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