MARYLAND FORM
502B

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

22502B049

2022

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
▶ 2. Social Security Number ________ 3. Relationship ________ 4. Regular ☐ 5. 65 or over ☐ 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 ________ 4. Regular ☐ 5. 65 or over ☐ 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 ________ 4. Regular ☐ 5. 65 or over ☐ 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 ________ 4. Regular ☐ 5. 65 or over ☐ 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 ________ 4. Regular ☐ 5. 65 or over ☐ 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 ________ 4. Regular ☐ 5. 65 or over ☐ DOB (MM/DD/YYYY) ▶ ________

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

22502B149

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) ▶ ______