MARYLAND FORM 502

RESIDENT INCOME TAX RETURN

195020050

2019

$

OR FISCAL YEAR BEGINNING _____ 2019, ENDING _____

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

Current Mailing Address Line 1 (**Street No. and Street Name or PO Box**)

Current Mailing Address Line 2 (**Apt No., Suite No., Floor No.**)

City or Town

State

ZIP Code + 4

REQUIRED: Maryland Physical address of taxing area as of December 31, 2019 or last day of the taxable year for fiscal year taxpayers. **See Instruction 6. Part-year residents see Instruction 26.**

4 Digit Political Subdivision Code (See Instruction 6)

Maryland Political Subdivision (See Instruction 6)

Maryland Physical Address Line 1 (Street No. and Street Name) (No PO Box)

Maryland Physical Address Line 2 (Apt No., Suite No., Floor No.) (No PO Box)

City

MD
State

ZIP Code + 4

Maryland County

FILING STATUS

CHECK ONE BOX ▶

See Instruction 1 if you are required to file.

1. [ ] Single (If you can be claimed on another person's tax return, use Filing Status 6.)
2. [ ] Married filing joint return or spouse had no income
3. [ ] Married filing separately, Spouse SSN ▶_____
4. [ ] Head of household
5. [ ] Qualifying widow(er) with dependent child
6. [ ] Dependent taxpayer (Enter 0 in Exemption Box (A) - See Instruction 7.)

PART-YEAR RESIDENT

See Instruction 26.

Dates of Maryland Residence (MM DD YYYY) FROM _____ **TO** _____

Other state of residence: ____

If you began or ended legal residence in Maryland in 2019 place a **P** in the box. . . . . ▶ [ ]

MILITARY: If you or your spouse has **non-Maryland** military income, place an **M** in the box. . . . . . . ▶ [ ]

Enter **Military Income** amount here: _____

EXEMPTIONS

See Instruction 10. Check appropriate box(es). **NOTE:** If you are claiming dependents, you **must attach the Dependents' Information Form 502B** to this form to receive the applicable exemption amount.

A. ▶ [ ] **Yourself** [ ] **Spouse** . . . . . Enter number checked [ ] See Instruction 10 **A. $** _____ . ____

B. ▶ [ ] 65 or over ▶ [ ] 65 or over
 ▶ [ ] Blind ▶ [ ] Blind . . . . Enter number checked [ ] X $1,000 . . . . **B. $** _____ . ____

C. ▶ Enter number from line 3 of Dependent Form 502B . . . . [ ] See Instruction 10 **C. $** _____ . ____

D. Enter Total Exemptions (Add A, B and C.) . . . . ▶ [ ] Total Amount. . . . **D. $** _____ . ____

COM/RAD-009

NAME   SSN

MARYLAND HEALTH CARE COVERAGE
See Instruction 3.

Check here ▶ ☐ If you do not have health care coverage   DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐ If your spouse does not have health care coverage   DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐ I authorize the Comptroller of Maryland to share information from this tax return with the Maryland Health Benefit Exchange for the purpose of determining pre-eligibility for no-cost or low-cost health care coverage.

E-mail address ▶ _____

INCOME
See Instruction 11.

1. Adjusted gross income from your federal return. . . . . ▶ 1. _____ . ___
1a. Wages, salaries and/or tips. . . . . ▶ 1a. _____ . ___
1b. Earned **income**. . . . . ▶ 1b. _____ . ___
1c. Capital Gain or (loss) . . . . ▶ 1c. _____ . ___
1d. Taxable Pensions, IRAs, Annuities (**Attach Form 502R.**) ▶ 1d. _____ . ___
1e. **Place a "Y" in this box if the amount of your investment income is more than $3,600**. . . . ▶ ☐

ADDITIONS TO INCOME
See Instruction 12.

2. Tax-exempt interest on state and local obligations (bonds) other than Maryland . . . . ▶ 2. _____ . ___
3. State retirement pickup. . . . . ▶ 3. _____ . ___
4. Lump sum distributions (from worksheet in Instruction 12.) . . . . ▶ 4. _____ . ___
5. Other additions (Enter code letter(s) from Instruction 12.) ▶ ___ ___ ___ ___ . . . . . ▶ 5. _____ . ___
6. Total additions to Maryland income (Add lines 2 through 5.) . . . . ▶ 6. _____ . ___
7. Total federal adjusted gross income and Maryland additions (Add lines 1 and 6.). . . . . 7. _____ . ___

SUBTRACTIONS FROM INCOME
See Instruction 13.

8. Taxable refunds, credits or offsets of state and local income taxes included in line 1 . . . . . . ▶ 8. _____ . ___
9. Child and dependent care expenses . . . . ▶ 9. _____ . ___
10a. Pension exclusion from worksheet (13A) . . . . **Yourself** ▶ ☐ **Spouse** ▶ ☐ . . ▶ 10a. _____ . ___
10b. Pension exclusion from worksheet (13E) . . . . **Yourself** ▶ ☐ **Spouse** ▶ ☐ . . ▶ 10b. _____ . ___
11. Taxable Social Security and RR benefits (Tier I, II and supplemental) included in line 1 . . . . ▶ 11. _____ . ___
12. Income received during period of nonresidence (See Instruction 26.) . . . . ▶ 12. _____ . ___
13. Subtractions from attached Form 502SU . . . . ▶ ___ ___ ___ ___ . . . . . ▶ 13. _____ . ___
14. Two-income subtraction from worksheet in Instruction 13 . . . . ▶ 14. _____ . ___
15. Total subtractions from Maryland income (Add lines 8 through 14.) . . . . ▶ 15. _____ . ___
16. Maryland adjusted gross income (Subtract line 15 from line 7.) . . . . 16. _____ . ___

DEDUCTION METHOD
See Instruction 16.

All taxpayers must select one method and check the appropriate box.

▶ ☐ **STANDARD DEDUCTION METHOD** (Enter amount on line 17.)

▶ ☐ **ITEMIZED DEDUCTION METHOD** (Complete lines 17a and 17b.)

17a. Total federal itemized deductions (from line 17, federal Schedule A) . ▶ 17a. _____ . ___
17b. State and local income taxes (See Instruction 14.) . . . . ▶ 17b. _____ . ___
    Subtract line 17b from line 17a and enter amount on line 17.
17. Deduction amount (Part-year residents see Instruction 26 (l and m).) . . . . ▶ 17. _____ . ___

18. Net income (Subtract line 17 from line 16.) . . . . 18. _____ . ___
19. Exemption amount from Exemptions area (See Instruction 10.) . . . . 19. _____ . ___
20. Taxable net income (Subtract line 19 from line 18.) . . . . 20. _____ . ___

NAME _____ SSN _____

MARYLAND TAX COMPUTATION	**21.** **Maryland tax** (from Tax Table or Computation Worksheet Schedules I or II) . . . . 21. _____ . ___
	22. Earned income credit (EIC)(See Instruction 18.). . . . . ▶ 22. _____ . ___

☐ Check this box if you are claiming the Maryland Earned Income Credit, but do not qualify for the federal Earned Income Credit.

23. Poverty level credit (See Instruction 18.). . . . . ▶ 23. _____ . ___

24. Other income tax credits for individuals from Part AA, line 13 of Form 502CR (**Attach Form 502CR.**) 24. _____ . ___

25. Business tax credits . . . .**You must file this form electronically to claim business tax credits on Form 500CR.**

26. Total credits (Add lines 22 through 25.). . . . . 26. _____ . ___

27. Maryland tax after credits (Subtract line 26 from line 21.) If less than 0, enter 0. . . . . 27. _____ . ___

LOCAL TAX COMPUTATION	**28.** Local tax (See Instruction 19 for tax rates and worksheet.) **Multiply line 20 by your local tax rate** .0 _____ or use the Local Tax Worksheet . . . . 28. _____ . ___

29. Local earned income credit (from Local Earned Income Credit Worksheet in Instruction 19.). . 29. _____ . ___

30. Local poverty level credit (from Local Poverty Level Credit Worksheet in Instruction 19.) . . . . 30. _____ . ___

31. Local tax credit from Part BB, line 1 of Form 502CR (**Attach Form 502CR.**). . . . . 31. _____ . ___

32. Total credits (Add lines 29 through 31.) . . . . 32. _____ . ___

33. **Local tax** after credits (Subtract line 32 from line 28.) If less than 0, enter 0 . . . . 33. _____ . ___

34. Total Maryland and local tax (Add lines 27 and 33.) . . . . 34. _____ . ___

CONTRIBUTIONS See Instruction 20.	**35.** Contribution to Chesapeake Bay and Endangered Species Fund . . . . ▶ 35. _____ . ___
	36. Contribution to Developmental Disabilities Services and Support Fund . . . . . ▶ 36. _____ . ___
	37. Contribution to Maryland Cancer Fund. . . . . ▶ 37. _____ . ___
	38. Contribution to Fair Campaign Financing Fund . . . . ▶ 38. _____ . ___

39. **Total Maryland income tax, local income tax and contributions** (Add lines 34 through 38.) . 39. _____ . ___

40. Total Maryland and local tax withheld (Enter total from your W-2 and 1099 forms and attach if MD tax is withheld.). . . . . ▶ 40. _____ . ___

41. 2019 estimated tax payments, amount applied from 2018 return, payment made with an extension request, and **Form MW506NRS** . . . . ▶ 41. _____ . ___

42. Refundable earned income credit (from worksheet in Instruction 21) . . . . ▶ 42. _____ . ___

43. Refundable income tax credits from Part CC, line 7 of Form 502CR (**Attach Form 502CR. See Instruction 21.**) . . . . 43. _____ . ___

44. Total payments and credits (Add lines 40 through 43.) . . . . 44. _____ . ___

45. Balance due (If line 39 is more than line 44, subtract line 44 from line 39. See Instruction 22.) . . . . ▶ 45. _____ . ___

46. Overpayment (If line 39 is less than line 44, subtract line 39 from line 44.). . . . . ▶ 46. _____ . ___

REFUND	**47.** **Amount of overpayment TO BE APPLIED TO 2020 ESTIMATED TAX** ▶ 47. _____ . ___
	48. Amount of overpayment **TO BE REFUNDED TO YOU** (Subtract line 47 from line 46.) See line 51 . . . . **REFUND** ▶ 48. _____ . ___

49. Check here ☐ if you are attaching Form 502UP. Enter interest charges from line 18 of Form 502UP _____ or for late filing_____ . . . . . . ▶ 49. _____ . ___

AMOUNT DUE	**50.** **TOTAL AMOUNT DUE** (Add lines 45 and 49.) **IF $1 OR MORE, PAY IN FULL WITH THIS RETURN. INCLUDE FORM PV.** . . . . 50. _____ . ___

NAME _____ SSN _____

DIRECT DEPOSIT OF REFUND (See Instruction 22.) Be sure the account information is correct. **For Splitting Direct Deposit**, see Form 588. If this refund will go to an account outside of the United States, then to comply with banking rules, place a "Y" in this box

► ☐ and see Instruction 22. For the direct deposit option, complete the following information clearly and legibly.

51a. Type of account: ► ☐ Checking ☐ Savings

51b. Routing Number (9-digits) ► _____ **51c.** Account Number ► _____

► _____ _____ ► _____ _____ _____
Daytime telephone no.   Home telephone no.   CODE NUMBERS (3 digits per line)

Check here ☐ if you authorize your preparer to discuss this return with us. Check here ► ☐ if you authorize your paid preparer not to file electronically. Check here ► ☐ if you agree to receive your 1099G Income Tax Refund statement electronically (See Instruction 24.)

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements and to the best of my knowledge and belief it is true, correct and complete. If prepared by a person other than taxpayer, the declaration is based on all information of which the preparer has any knowledge.

_____ _____ _____ _____
Your signature   Date   Spouse's signature   Date

_____   _____
Printed name of the Preparer / or Firm's name   Street address of preparer or Firm's address

_____   _____
Signature of preparer other than taxpayer **(Required by Law)**   City, State, ZIP Code + 4

                                          _____ ► _____
                                          Telephone number of preparer   Preparer's PTIN **(Required by Law)**

For returns filed without payments, mail your completed return to:

Comptroller of Maryland
Revenue Administration Division
110 Carroll Street
Annapolis, MD 21411-0001

For returns filed with payments, attach check or money order to Form PV. Make checks payable to Comptroller of Maryland. Do not attach Form PV or check/money order to Form 502. Place Form PV with attached check/money order on TOP of Form 502 and mail to:

Comptroller of Maryland
Payment Processing
PO Box 8888
Annapolis, MD 21401-8888

MARYLAND FORM 502B

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

19502B050

2019

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

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

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

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

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

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

COM/RAD-026

MARYLAND FORM
502B

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

19502B150

NAME _____ SSN _____

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

Social Security Number
► 2. _____   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 _____

Social Security Number
► 2. _____   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 _____

Social Security Number
► 2. _____   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 _____

Social Security Number
► 2. _____   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 _____

Social Security Number
► 2. _____   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 _____

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

Check here ► ☐ if this dependent does not have health care coverage
DOB (MM/DD/YYYY) ► _____

COM/RAD-026