Hugh D. Cox
Attorney at Law
North Carolina Bar Number 6567
2411 B Charles Boulevard; Post Office Box 154
Greenville, North Carolina 27835-0154
Tel: (252) 757-3977; Fax: (252) 757-3420; email: hughcox@hughcox.com

July 18, 2012

We MUST know the date of your last denial immediately.
Appeals must be filed within 60 or 65 days of denial.

[CLAIMANT FULL NAME]
[CLAIMANT STREET ADDRESS]
[CITY, STATE ZIP]

Dear [TITLE LASTNAME]:

Thank you for contacting my law office about your Social Security disability claim. I will be honored to represent you. If you have not yet applied for Social Security disability, I ask that you do so as soon as possible without entering into a contract with me to see if you win your case without an attorney or without owing an attorney fee. If your first application is denied, you can contact me and I will be glad to represent you at that time. If you win your first application, you should not owe an attorney if the system works fairly.

If you decide to hire me to represent you, I ask that you sign the THREE attached contracts and return them to my office as soon as possible. To make certain that we received the contracts, you should contact my office within one week of mailing or delivering these contracts to insure that we received them. One goes to the SSA since they must approve my fee, another goes to you (by email or mail) and I keep one. Until I receive your signed contracts and I sign the same three contracts and give you an original, I do NOT yet represent you. Please help me make certain that I receive all three signed contracts so that I can sign these and give you an original contract. I will then send you a formal letter stating that I represent you.

I am very concerned about the time for an appeal. Your appeal must be filed within 60 days of the last denial. That means that I must have a copy of your last denial within 30 days after you receive it. Please insure that you provide me with a copy of your last denial immediately so that I know when the deadline is for the last day to appeal your case.

I admit that I am an attorney who relies on clients to fill out my forms. I insist that you fill out the forms that I provide to you and that you return them to my office as soon as possible. Cases are won on written information from the claimant, the doctor, and from lawyer. I will also ask you to present forms to your physicians to prove your disability. I find it is best that patient deals with the doctor rather than the attorney being involved. Then we know if the doctor really supports the claimant's disability.

You need to treat our forms as "opportunities" rather than "burdens" If you have severe back problems and you indicate on a form that you can walk a mile with no problem, you

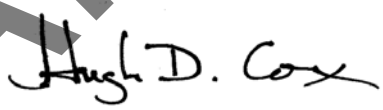
probably will not win your case. Please answer all forms and questions honestly and realistically to show your full physical and mental limitations.

Much of my work involves reading lengthy and complicated medical reports and evaluating evidence to be compiled into a brief or document about your case. I spend much of each day writing briefs or research. I tell my staff NOT to interrupt me with telephone calls. If you need to communicate with me, you must do so through my staff. I will answer your emails to hughcox@hughcox.com with short responses. I often require several days to return phone calls. For me, the choice is to work on cases or talk on the telephone, and I choose working on client cases. I hope you understand.

Please be prepared for a long process of appeal. Currently, the Social Security process of determining disability takes more than two years. The time for a hearing before an Administrative Law Judge is 19 months at the Raleigh Regional SSA office. This extraordinary length of time places a great hardship on disabled people who must survive financially on the resources of family and friends. Lawyers are prohibited by the Rule of Professional Conduct from providing money to clients. Please prepare yourself for this long ordeal.

I look forward to helping you with your case. Please feel free to communicate with me through my staff or by email.

Sincerely,



Hugh D. Cox

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We MUST know the date of your last denial immediately.

Status: [OTHER BENEFITS]

We also need to know if you received unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, VA benefits, DMV Handicapped sticker, or Federal Employee Retirement System (FERS) benefits after your disability onset date.

Sample email text to be used in email message:

Dear [TITLE LASTNAME],
I am honored that you contacted me. I want to represent you in your claim for Social Security disability benefits.
My first concern is that we must appeal your case within 60 days of the last denial. Can you provide me with that date? We want to appeal on time.
If you have no claim at the present time and you wish to apply, we can take care of that application online.
I should also mention that if you receive benefits from a private disability insurance plan, that insurance company will sometimes provide you with an attorney at no cost so they can recoup their money. In other words, you may owe your short or long term disability plan for the Social Security benefits you receive back to the insurance company (up the amount of Social Security you receive). That is why some disability insurance plans will provide you with a free lawyer.
You might want to check to see if your short or long term disability insurance plan requires repayment and whether they will provide you with a free attorney.
Attached to this email is my “kit” that I send potentials clients containing a cover letter with contract, questionnaires, and forms. Until you return my contract and I sign it, I do not represent you.
One thing I always look for in cases like yours is pain clinic treatment – often with psychological care. Chronic pain always causes mental health issues. Medical records win these cases.
Thank you for contacting me.
Many thanks,
Hugh Cox

AUTHORIZATION TO REPRESENT IN SOCIAL SECURITY CASE

I, **[CLAIMANT FULL NAME]**, agree to hire Hugh D. Cox, 2411B Charles Blvd., Greenville NC 27835-0154, as my attorney to represent me in obtaining my Social Security Disability Benefits.

I understand that the Social Security Administration (SSA) must approve any fee my attorney charges or collects from me for legal services before SSA in connection with my claim(s) for benefits.

I agree that if the SSA favorably decides any of my claim(s) pursuant to this contract, I will pay my attorney 25 percent of the past-due benefits resulting from my claim(s) up to a maximum of $6,000.00, whether the past due benefits are Supplemental Security Income (SSI under Title XVI), Disability Insurance Benefits (DIB under Title II), Disabled Widow's Benefits, Disabled Child's Benefits, or any combination thereof.

For disability insurance benefits claims under Title II, I understand that Social Security past-due benefits are the total amount of money that I and any auxiliary beneficiaries (including my children and surviving spouse if any) become entitled on my claim.

For SSI claims under Title XVI, I understand that Supplemental Security Income past-due benefits are the total amount of money for which I become eligible through the month SSA makes a favorable SSI decision on my claim.

For combination SSI under Title XVI and insured benefits under Title II claims, I understand that Social Security past-due benefits are the total amount of money to which I and any auxiliary beneficiaries (including my children and surviving spouse if any) become entitled. I further understand that attorney fees for both claims are 25 percent of the past-due benefits resulting from my claim(s) up to a maximum of $6,000.00.

I understand that separate and apart from attorney's fees, I am to pay the actual costs of litigating my Social Security Disability claim, whether successful or not. My attorney will attempt to seek my advance approval for such expenses that exceed $50.00 per incident of cost. My attorney will notify me of any incident of cost exceeding $50.00 if he has advanced notice. I will advance all costs to be paid by my attorney directly related to this Social Security claim to include the cost of medical records, physician and expert fees, telephone calls, copying costs, labor costs for reproduction of my file (not to exceed $50.00), travel expenses at $.45 per mile and other such actual expenses. I further agree to sign any and all necessary forms in order for my attorney to obtain medical information on this case. I agree to go to each of these medical facilities to request these medical records prior to my attorney writing for them. I agree to cooperate with my attorney by meeting with him when requested and to attend hearings or examinations when scheduled.

Upon receiving a favorable decision, my attorney shall have the responsibility of withdrawing from my case so as to incur no further representation or costs.

I understand and agree to what is written above.

This the following Date:	**Wednesday, July 18, 2012**
Client Name:	**[CLAIMANT FULL NAME]**
address:	**[CLAIMANT STREET ADDRESS]**
	[CITY, STATE ZIP]
telephone**:**	**[TELEPHONE NUMBER]**
Social Security Number	**[SOCIAL SECURITY NUMBER]**

_____

[CLAIMANT FULL NAME], Claimant

I agree to act as attorney on the above stated basis.

_____

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Social Security Number	**[SOCIAL SECURITY NUMBER]**

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Client Name:	**[CLAIMANT FULL NAME]**
address:	**[CLAIMANT STREET ADDRESS]**
	[CITY, STATE ZIP]
telephone**:**	**[TELEPHONE NUMBER]**
Social Security Number	**[SOCIAL SECURITY NUMBER]**

_____

[CLAIMANT FULL NAME], Claimant

I agree to act as attorney on the above stated basis.

_____

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SOCIAL SECURITY CASE INITIAL FORM TO BE COMPLETED BY POTENTIAL CLIENT:

(Fill out completely. Consider this form as an opportunity and not a burden)

WHEN WAS THE DATE YOU ACTUALLY BECAME DISABLED -- CLAIMED ONSET DATE: (CHECK PIA)
Ave you been awarded MEDICAID either now or in the past? ☐YES ☐NO (If YES, get copy of Award.)
FULL NAME: [CLAIMANT FULL NAME] email [EMAIL ADDRESS]
STREET ADDRESS:
CITY STATE ZIP:
TELEPHONE (h) (o)
TELEPHONE NUMBER OF SOMEONE WHO CAN ALWAYS CONTACT YOU:
WHO IS THIS PERSON WHO CAN ALWAYS CONTACT YOU:
SOCIAL SECURITY NUMBER: DATE OF BIRTH: AGE
LAST DAY YOU ACTUALLY WORKED:
WERE YOU ACTUALLY DISABLED BEFORE YOUR LAST WORK DATE, BUT CONTINUED TO WORK: ☐YES ☐NO
WHAT SOCIAL SECURITY BENEFITS DID YOU APPY FOR: ☐DISABILITY ☐SSI ☐SURVIVOR/WIDOW(ER)
HAVE YOU APPLIED BEFORE FOR SOCIAL SECURITY DISABILITY AND BEEN DENIED, ABANDONED YOUR APPEAL, THEN TRIED AGAIN WITH A NEW CLAIM: ☐YES ☐NO
IS THIS AN SSI CASE ONLY? ☐YES ☐NO
SPOUSE FULL NAME YOUR CHILDREN'S AGES:
SPOUSE JOB TITLE/EMPLOYER:
DO YOU EARN ANY MONEY NOW: ☐YES ☐NO DO YOU RECEIVE ANY PUBLIC ASSISTANCE: ☐YES ☐NO
EDUCATION: ☐COMPLETED ___ TH GRADE IN SCHOOL ☐HIGH SCHOOL ☐MORE THAN HIGH SCHOOL
YOUR VOCATIONAL EDUCATION (IF YOU LEARNED A TRADE, OCCUPATION OR SKILL): ☐YES ☐NO
DO YOU HAVE A LEARNING DISABILITY: ☐YES ☐NO
DID YOU SERVE IN THE MILITARY: ☐YES ☐NO WHAT SERVICE: WHAT YEARS:
HIGHEST RANK: HONORABLE DISCHARGE: ☐YES ☐NO
DID YOU SERVE IN COMBAT: ☐YES ☐NO
Does the VA, Workers Comp Agency or any Insurance consider you disabled? If YES, who?
Do you receive any VA compensation?
CAUSES OF YOUR DISABILITY (IN ORDER OF MOST DISABLING TO LEAST DISABLING)
1
2
3
4
5
6
7
8
WHO DO YOU LIVE WITH?
WHO TAKES CARE OF YOU?
ABILITY TO TRAVEL: ☐ I DRIVE ☐I HAVE A DRIVER'S LICENSE I OWN A VEHICLE
MILES DRIVEN PER WEEK: TIMES DRIVING PER WEEK:
☐RIGHT HANDED ☐LEFT HANDED HEIGHT/WEIGHT
PHYSICIANS WHO TREATED YOUR DISABILITY:

NAME	ADDRESS	SPECIALITY	STILL SEEING	DATES SEEN	RESTRICTIONS
1					
2					
3					
4					
4					
5					
6					
7					
8					

What physicians support your claim for disability?
WERE YOU IN A HOSPITAL IN LAST 5 YEARS:

NAME	ADDRESS	TREATMENT	DATES

[OTHER BENEFITS] - Did you receive unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, VA benefits, or Federal Employee Retirement System (FERS) benefits after your disability onset date?

PATIENT/CLAIMANT'S WORK BACKGROUND

NAME OF PATIENT/CLAIMANT: **SOCIAL SECURITY NUMBER:**

[CLAIMANT FULL NAME] **[SOCIAL SECURITY NUMBER]**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

To be completed by the claimant - Please prepare facts carefully before entering any information. Wrong information can be embarrassing. Start at the top with your most recent job first, followed by next most recent job (and so on), and list all jobs performed within the past 15 years. Weight lifted information is to be considered a *single* object weight and not weights added:

Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
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Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job
Dates of Employment From: To: ☐Full-time ☐Part-time	Employer and Address	Job Title or Duties Performed largest object weight lifted per day: Lbs Average object weight lifted per hour: Lbs	Reason for Leaving Job

(If additional space is needed, use back of form)

SIGNATURE	DATE

PRESCRIPTION MEDICATIONS LIST

NAME OF PATIENT/CLAIMANT: **[CLAIMANT FULL NAME]**

SOCIAL SECURITY NO: **[SOCIAL SECURITY NUMBER]**

1. ☐ SOCIAL SECURITY CASE	☐ WORKERS COMPENSATION CASE	☐ VETERANS CASE

Please list all PRESCRIPTION Medications you are CURRENTLY taking plus the information asked. Please be accurate and give full information requested to include dosage:

Name of Medication and Dosage	Date first Prescribed	Daily Amount Taken	Reason for Medication	Physician Name	Adverse Effects such as stomach upset, dizzy, etc.

*Please list below any **NON-PRESCRIPTION** medications you are taking, how often you take them, and the reason for taking them*

(If additional space is needed, use another form)

SIGNATURE	DATE

SOCIAL SECURITY TELEPHONE CONTACTS INFORMATION:
Filenames_TELEPHONE_EMAIL_KIT_generic_2010_10_25

NAME: **[CLAIMANT FULL NAME]** DATE: [TODAY'S DATE]
SSN: **[SOCIAL SECURITY NUMBER]** EMAIL: [EMAIL ADDRESS]
ADDRESS: **[CLAIMANT STREET ADDRESS] . [CITY, STATE ZIP]** COUNTY: [COUNTY]

PHONES: (HOME): **[TELEPHONE NUMBER]** (CELL):

LOCAL SOCIAL SECURITY OFFICE: [LOCAL SSA OFFICE]

PRIOR APPLICATIONS – OR IS FIRST APPLICATION STILL ACTIVE? [PRIOR APPLICATION?]

DATE LAST DENIED: [DATE OF LAST DENIAL]

DATE LAST WORKED: [DATE LAST WORKED][DATE LAST WORKED]

AGE/DOB: [DATE OF BIRTH] EDUCATION: [HIGHEST EDUCATION]

DATE DISABILITY STARTED: [DISABILITY ONSET DATE]

DATE LAST WORKED:

SUMMARY OF WORK HISTORY -- CLIENT'S USUAL OCCUPATION: [OCCUPATION]

Military: [MILITARY SERVICE]

DIAGNOSES CAUSING DISABILITY:
[DISABILITY DIAGNOSES]

PHYSICIANS: [PHYSICIANS AND ADDRESSES] PHYSICIAN SUPPORTS SS DISABILITY?:
[PHYSICIANS WHO SUPPORT DISABILITY]

VA

REMARKS

[OTHER BENEFITS] Did you receive unemployment compensation, workers compensation, short or long term disability benefits, insurance plan disability benefits, VA benefits, or Federal Employee Retirement System (FERS) benefits after your disability onset date?

( )NEEDS KIT sent to claimant above and needs s_disability forms KIT for potential clients_2006_03_05.doc once contract is

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
EASTERN DIVISION
No.

[CLAIMANT FULL NAME] Plaintiff,	)
	)
v	)
	)
MICHAEL J. ASTRUE	)
COMMISSIONER OF	)
SOCIAL SECURITY,	)
Defendant	)
	)

DECLARATION OF NET WORTH BY CLAIMANT

I, [CLAIMANT FULL NAME], a resident of [COUNTY] County with my address at [CLAIMANT STREET ADDRESS], [CITY, STATE ZIP], declare that at all times and at the time my appeal to the U. S. Federal Court for Social Security Claims was filed on the date shown, my estate, including all properties, monies, and possessions, combined to a net worth of less than Two Million Dollars ($2,000,000.00).

I certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

This the following date: _____,

[CURRENT YEAR]

_____
[CLAIMANT FULL NAME]

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
[CLAIMANT FULL NAME]	**[SOCIAL SECURITY**
Wage Earner (If Different)	Social Security Number

APPOINTMENT OF REPRESENTATIVE

I appoint this person, **HUGH D. COX, Attorney at Law**
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s)

☑ Title II (RSDI) ☑ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☑ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____ .
(Name of Principal Representative)

Signature (Claimant)	Address
	[CLAIMANT STREET ADDRESS] . [CITY, STATE
Telephone Number (with Area Code) **[TELEPHONE NUMBER]**	Fax Number (with Area Code) / Date **7/18/2012**

I, **HUGH D. COX, Attorney at Law**, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless ithas been approved in accordance with the laws and rules referred to on the reverse side of therepresentative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notifythe Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☑ I am an attorney. ☐ I am a non-attorney who is participating in the direct fee payment demonstration project.

☐ I am a non-attorney . I am not participating in the direct fee payment demonstration

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as attorney. ☐ Yes ☑ No

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☑ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address
	PO Box 154, Greenville, NC 27835
Telephone Number (with Area Code) **(252) 757-3977**	Fax Number (with Area Code) **(252) 757-3420** / Date **7/18/2012**

Part III (Optional) **WAIVER OF FEE**

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. Irelease my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or

Signature (Representative)	Date

Part IV (Optional) **WAIVER OF DIRECT PAYMENT**

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative Waiving Direct Payment)	Date