



**LOST COPY DECLARATION AND INDEMNIFICATION  
REQUEST FOR DUPLICATE COPY**

1116 West Riverside Avenue, P.O. Box 1445, SPOKANE, WA 99210  
509-838-4235 800-541-5858 www.nclife.com

Policy No. \_\_\_\_\_ Insured \_\_\_\_\_ Owner \_\_\_\_\_  
(If other than insured)

As owner of this policy, undersigned requests company to issue a duplicate policy or grant benefits under such policy as requested herein, without requiring surrender of the policy, because policy is lost or has been destroyed.

Undersigned declares to best of his/her knowledge that no person other than undersigned has any interest in, or right to, said policy or any of its benefits, privileges and advantages.

In consideration of issuance of duplicate policy or granting of requested benefits under such policy without requiring surrender of policy, undersigned agrees to indemnify company from all losses which may directly or indirectly result from the granting of this request. Undersigned further agrees that the duplicate policy, if issued, shall supersede and replace the lost policy for all purposes, and that if lost policy is found it shall promptly be returned to the company.

I direct that any amendment of the policy requested above be effected by return of a copy of this request with the Company's acknowledgment. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement, but may require such presentation if desired.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Owner

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— FOR HOME OFFICE USE ONLY —  
ACKNOWLEDGMENT OF REQUEST FOR CHANGE — PLEASE ATTACH TO POLICY  
North Coast Life Insurance Company has recorded the Change requested and retained the original of the request.

\_\_\_\_\_  
Date Accepted

\_\_\_\_\_  
Secretary

**Fee for Lost Policy - \$20**