

September 21, 2006

To whom it may concern:

Mitsui Sumitomo Insurance Co., Ltd.

Current Status of Business Improvement Plan Implemented

Mitsui Sumitomo Insurance Co., Ltd. (“the Company”) (President & CEO Toshiaki Egashira) has today submitted the second report on the current status of implementation of the business improvement plan. The Company submitted the plan to the Financial Services Agency as of July 21, 2006, and has been taking specific measures thereunder since then. Here is an outline of the report as set forth below.

1. Improvement and Strengthening of Corporate Governance

1.1 First Meeting of Audit Committee

The Company newly established the Audit Committee as an organ that reviews operations, internal audit and legal compliance in place, and the committee had its first meeting on September 19, 2006.

At the meeting, the committee received the reports on internal audit guidelines, methods to monitor operations in place at the Corporate Quality Control Department, recent progress of the business improvement plan, etc. and the members of and advisors to the committee, particularly outside directors, discussed actively in response to these reports presented.

To give some actual examples of opinions raised there, “The questionnaire to the consuming public conducted by the Corporate Quality Control Department should continue to be implemented regularly and extended to multilevel targets,” “In editing a Standard Policy Interpretations, policy provisions should be interpreted from the customer-first view of ‘insurance company as a member of society’ referred to in the recent court decision,” “In bid to ensure appropriate claim payments of the medical insurance products in the third sector, an accumulation of cases examined at the Claims Payment Examination Council should be utilized effectively in addition to revision of internal rules and manuals,” and so on. The committee agreed that these opinions should be reflected in improving operational systems.

1.2 Implementation of Corporate Governance Training for Directors and Executive Officers

A corporate governance seminar was held for the directors and executive officers with a crisis management expert invited thereto, dealing with corporate crisis management and legal compliance. Using actual examples, the case study focused on complaints from outside as significant clue to grasping a critical issue inside the organization and problems which a company in general is likely to fall into in building a legal compliance system, and then moved to discussion on how to practically apply these lessons learned in real operations.

1.3 Dramatic Reform of System of Reporting on Business Operations

(a) Corporate Quality Control Department Established and Started up

The Corporate Quality Control Department was newly established on September 1, 2006 and started its service with deliberating control document such as the Standard Policy Interpretations which contains those prepared by the respective product departments to govern claims handling properly and the Criteria in Determination as Ineligible Claim prepared by the Claims Administration Department.

(b) Strengthening Communication between Management and ‘Front-Line’ Employees

The “Meet the Management” campaign was launched for communication of between management and front-line employees. The chairman, the president and other

management members visit departments and branch offices and talk with front-line employees there about operational issues and solutions thereto. Suggestions collected in this way will be reflected in a “new group vision” being prepared towards the end of this fiscal year, as tentatively set, and in the “*Tsukuru Kawaru* (Create-and-Change) Project” aimed at creating a new corporate culture.

(c) Strengthening Communication with Agents

Management exchanged opinions with the representatives of agents across Japan at the “MSA (which is an organization of the Company’s top-tier agents in the country) Secretariat Meeting” held on August 30, 2006. A sincere discussion was made in response to suggestions sent from agents nationwide, and “improvement of the claims handling system” and “plain-and-easy-to-understand product development” were confirmed as issues to be focused on in the ongoing efforts.

1.4 Dramatic Improvement and Strengthening of Internal Audit System

(a) Internal Audit Principles Determined for Second Half of Fiscal 2006

A discussion was made on effectiveness of the internal audit guidelines for the second half of fiscal 2006 at the first meeting of the Audit Committee. In the second half and onward, internal audit will be tighter mainly by conducting on-site inspection with no prior notice and placing weight on accountability of explanation to policyholders and claims payment liability as a checkpoint in the coming session.

(b) Strengthening of Internal Audit System on Claims Payment Administration

Personnel of the internal auditing was reinforced from 64 to 97 persons as of September 1, 2006, and specifically for the internal auditing of the claims handling division, dedicated staff increased 9 persons to 19, from 10 as of early in this fiscal year. An intensive audit is scheduled for the regional claims departments by December to check up appropriateness in their claims administration systems.

2. Improvement and Strengthening of Claims Payment Administration System, etc.

2.1 Dramatic Review and Improvement of Claims Payment Administration System

(a) “Standard Policy Interpretations” and “Criteria in Determination as Ineligible Claim” Prepared

The Standard Policy Interpretations and the Criteria in Determination as Ineligible Claim were prepared to avoid employees in the claims handling division from misunderstanding in interpretation of policy and prevent claims handling service from varying from an employee to another and to secure thereby fairness, transparency and appropriateness.

(b) Claims Payment Examination Council, etc. Established

The Claims Payment Examination Council (“CPEC”), which is comprised of outside experts (a lawyer, a representative of consumer group and a doctor) and others, was newly established on September 1, 2006. The CPEC has commenced its activity with examination on claims payments of third sector products, and works on those cases which may be subject to the provisions in regard to cancellation due to violation of duty to provide proper health condition statement and onset of illness prior to the effective date.

Meanwhile, a long-term medical service center will be set up as of October 1. Scattering claims handling administration of whole-life medical insurance will be concentrated and integrated at the center, and the Company will provide highly professional, fair and equitable services.

(See Attachment 1: Claims Payment Examination Council Established and Examination on Third-Sector Medical Insurance)

(c) Claims Handling Consulting Section Established and Started up

The Claims Handling Consulting Section was newly established on September 1, 2006

and commenced its service as customer desk to deals with general inquiries, consultation requests and complaints from customers. In respect of complaint received, the section requests a report on particulars of the case from a service center relevant thereto, instructs the center, if necessary, to re-examine the case and serve the customer based on the findings and conclusion.

(d) Continued Disclosure about Claims Payment, etc.

The Company continues to comprehensively review the progress on claims in process and to disclose the results obtained in a timely and appropriate manner. The Company will also disclose customer complaints about claims handling and examples of claims denied as ineligible pursuant to policy clauses.

(See Attachment 2: Non-payments for Incidental Expenses and Inappropriate Denials of Third-Sector Whole-Life Medical Claims)

2.2 Dramatic Review and Improvement of Product Development System

In the development, improvement and elimination of products, "Product Development Guidelines" as well as "Controlling Rules in Product Development," which governs "product development," "underwriting," "sales and solicitation" and "post-sale monitoring" phases at the relevant sections within the organization, have been revised. For paving the way forward towards building a product development system, the Company will mainly seek to strengthen cooperation between the divisions of product development, claims handling and computer systems, manage product development process in accordance with a flow chart, prove validity of flow charts of product development at the Corporate Quality Control Department, reflect customers' comments collected in the monitoring in the product development.

3. Improvement and Strengthening of Policyholder Protection and Policyholder Benefits

3.1 Establishment of Employee and Agent Administration System

< Compliance-Focused Evaluation System Introducing >

The Company will adopt a compliance-focused evaluation system of officers and employees in October 2006. Under the system, 'legal compliance' and 'putting the first priority on the customers' view' will become independent criteria for evaluation and will manifest the Company's commitment to compliance in the context of personnel evaluation.

3.2 Dramatic Review and Improvement of Complaints Response and Handling System

(a) Complaints Response Guidelines Formulated

Based on its conviction that building and maintaining a well-prepared complaints response system is vital for the Company to keep its daily operations sound and proper in the insurance business, response to complaint guidelines were formulated for the purpose of building such a system to handle complaints appropriately. The Company is going to utilize customers' complaints effectively as "evocative and critical information to improve its operations."

(See Attachment 3: Customers' Complaints and Response thereto)

(b) Council on Promotion of Customers' Viewpoint to Be Established

The Company resolved to establish the "Council on Promotion of Customers' Viewpoint" as of October 1, 2006. The council, with a majority composed of external members, will function as a consultation organization for the Board of Directors, analyze customer comments, including complaints collected and summarized by the Customer Service Department, and recommend measures that would contribute to policyholder protection and policyholder benefits to the Board.

4. Improvement and Strengthening of Legal Compliance System and Handling System for

Incidents of Misconduct

4.1 Legal Compliance System for Strengthening Internal Supervisory Functions Established

(a) Provision of Written Pledges by Officers and Employees

All officers and management-level employees requested by the Company have submitted their written pledges on legal compliance addressed to the president. By this action, the Company intends to root firmly compliance awareness in the business approach across the organization.

(b) “Criteria in Determination of Incident as Misconduct” Revised

To ensure appropriateness in determining an incident of misconduct, the Criteria in Determination of Incident of Misconduct were revised, endorsed by the Audit Committee at its first meeting. The criteria not only define incident of misconduct concretely by showing example cases which fall within the definition but stipulate that at least two lawyers shall separately examine a doubtful case in order to ensure appropriateness in determining an incident of misconduct and get ready for a possible case in future.

4.2 Survey and Analysis on Cases Related to Legal Compliance and Remedies

State of legal compliance are now being thoroughly examined under the “Compliance Enhancement Month” campaign (August through September).

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Claims Payment Examination Council Established and Examination on Third-Sector Medical Insurance

1. Purpose of Establishment

The Claims Payment Examination Council (“CPEC”) was established as one of pillars for building a fair and precise examination system and procedure in real term which ensure that all customers are treated fairly and appropriately in the claims handling, particularly in respect of third-sector medical insurance, and prevent inappropriate non-payment of claim from recurrence.

2. Outline of Responsibility

In consideration of fully securing protection of policyholders, etc., particularly with regard to third-sector insurance product, the CPEC examines claims which may fall under certain policy provisions for ineligibility including ones involving “violation of duty to provide proper health condition statement,” and determines the propriety of applying those provisions to cases under review as well as the eligibility of each claim.

The CPEC also examines the propriety of decisions where an appeal has been filed by a customer dissatisfied with the decision to deny a claim.

3. Recent Examination Results (of the claims of third-sector insurance as of September 19, 2006)

The CPEC started its examination service on third-sector claims on September 7, 2006 and has concluded 19 cases as of September 19, 2006. Out of these 19 cases, 14 have been concluded due to pay and 5 not.

< Outline of 5 Cases Concluded Ineligible >

(as of September 19, 2006)

case	claim	remarks on case
Cancellation due to violation of duty to provide proper health condition statement	Hospitalization due to illness and Hospitalization for operation	A claim for expenses pertaining to hospitalization due to renal calculus and for its fracturing operation: It has been revealed that the claimant was in hospital, once prior to signing the application, for operation on “ureteral stone” after diagnosed with “ureteral stone” and “renal calculus.” Causation is recognized between the claimed illness and the fact of violation of duty of health disclosure. The CPEC therefore determined that the claim violated the said duty and the policy was to be cancelled with denying the claim for payment.
Cancellation due to violation of duty to provide proper health condition statement	Hospitalization due to illness, Hospitalization for operation and Outpatient treatment related to hospitalization	A claim for expenses of removal operation of cholecystolithiasis and hospitalization and outpatient expenses pertaining thereto: It has been revealed that the claimant took doses as diagnosed with “cholelithiasis” two months prior to signing of the application. The claimant continued to take doses thereafter until the operation. The CPEC therefore determined that the claim violated the said duty and the policy was to be cancelled with denying the claim for payment.
Cancellation due to violation of duty to provide proper health condition statement	Hospitalization due to illness	A claim for expense of hospitalization due to interstitial cystitis: It has been revealed that the claimant was diagnosed with “interstitial cystitis” a year prior to signing of the application, visited hospital every one or two months and continuously took doses. The CPEC therefore determined that the claim violated the said duty and the policy was to be cancelled with denying the claim for payment.
Cancellation due to violation of duty to provide proper health	Hospitalization due to illness and Hospitalization for operation	A claim for expenses pertaining to hospitalization due malum coxae deformans and operation therefor: It has been revealed that the claimant was diagnosed with the said arthralgia two months prior to signing of application, visited hospital every one or two months and continuously

condition statement		took doses. The CPEC therefore determined that the claim violated the said duty and the policy was to be cancelled with denying the claim for payment.
Cancellation due to violation of duty to provide proper health condition statement	Hospitalization due to illness and Hospitalization for operation	A claim for expenses pertaining to hospitalization due cataract and operation therefor: It has been revealed that the claimant was diagnosed with the said disease prior to signing of the application, visited hospital every three months and continuously took doses. The CPEC therefore determined that the claim violated the said duty and the policy was to be cancelled with denying the claim for payment.

[Terminology]

Cancellation due to violation of duty to provide proper health condition statement	A provision of policy that, in case where a policyholder failed intentionally or grossly negligently to disclose material facts to be disclosed under the policy clauses, or thereunder expressed a false statement upon signing of the application (including restoring a policy once released, early terminated or cancelled), the insurer may cancel the policy signed.
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Non-payments for Incidental Expenses and Inappropriate Denials of Third-Sector Whole-Life Medical Claims**1. Recent Progress of Follow-up of Non-payments (as of September 20, 2006)**

Investigation has been conducted on cases of non-payment or failure to properly pay extraordinary and incidental expenses pertaining to those claims paid during the period from April 2002 to June 2005. 45,105 cases or 98.8 percent out of 45,641 cases once found not yet paid fully have now been duly paid out as of September 20, 2006.

As for cases impractical and not yet unsettled, the Company continues to make efforts to find those customers who are unavailable for contact due to moving or any other reason as well as make a settlement without delay with those customers whose accounts for wire transfer are yet to be confirmed.

Furthermore, to achieve fair and appropriate settlement with all deserving customers, the Company is currently conducting a reexamination to confirm that there remains no such case as omitted by error that should have been extracted from the data and subject to the previous examination. In addition, the Company is making an investigation and examination on such cases involving combinations of supplemental coverage under automobile policies as set forth below, where a possibility of complementary payment exists. The Company will announce the results of these efforts as they become available.

< case 1 > In case where a fellow passenger on the insured car was indemnified under the bodily injury liability insurance and driver's personal accident insurance, extraordinary and incidental expenses may also have been reimbursed under the bodily injury insurance,

< case 2 > In case where a fellow passenger on the insured car was indemnified under the bodily injury liability insurance and personal accident insurance together with medical expenses, compensation for sequela, etc. under the single-car accident insurance and a driver was paid medical expenses under the driver's personal accident insurance, compensation for sequela, etc. may have been paid to the driver,

< case 3 > In case where medical expenses, compensation for sequela, etc. were paid under the driver's personal accident insurance and medical expenses were paid under the single-car accident insurance, compensation for sequela, etc. may have been paid to the driver,

and so on.

2. Recent Progress of Inappropriate Denials of Third-Sector Whole Life Medical Claim (as of September 20, 2006)

Investigation and examination have been made on appropriateness in the determination in respect of claims denied during the period from April 2004 to March 2006. 793 cases or 85.5 percent of 927 cases thus found as inappropriate non-payment have been duly settled as of September 20, 2006.

The Company continues to make efforts to seek out those customers who are unavailable for contact due to moving or any other reason as well as have a preliminary discussion with those customers whose policies have once been released, early terminated or cancelled in sight of restoring the policies to settle without delay.

Furthermore, the Company is conducting a thorough investigation and examination of third sector product claims, covering claims made as early as during fiscal year 2001. The Company will announce the results of the examination as they become available.

Attachment 3 Customers' Complaints and Response thereto

The Company discloses customers' complaints received during fiscal 2005 (April 2005 to March 2006) as part of measures taken to be 'a company that puts the first priority on the customers' view' with the commitment that it sincerely listen to customers and ensure its operations acceptable in the public eye.

Shown hereunder are the number of complaints received by category and an overview of customer complaints generally covering fiscal 2005 and the period from April to July 2006.

1. Outline of Comments (Complaints) Raised by Customers

The Company classifies comments from customers into "complaint, request or inquiry," and defines complaint as "customer's expression of dissatisfaction."

The Company recorded 9,523 cases of customer's expression of dissatisfaction (i.e., complaint) during fiscal 2005. Cases of customer's expression of dissatisfaction have increased sharply, particularly in the classifications of complaints regarding "payout in the past," "poor customer service" and "poor management in respect of the administrative measures" mainly due to the administrative measures the Company received in June, 2006, and the number has reached almost as high as that for the entire previous year.

Customers' complaints are found scattering on various phases and ranging broadly from solicitation activity through claims handling, and based on this finding, complaints are classified into the categories of "sales and solicitation," "policy administration and maintenance," "claims handling," "customer reception," "protection of customers' privacy" and "others."

< Complaints by Category > (number of cases)

	Fiscal 2005 (April 2005 – March 2006)				
	Q1	Q2	Q3	Q4	Total
Sales and solicitation	461	418	531	478	1,888
Policy administration and maintenance	949	779	1,032	760	3,520
Claims handling	629	766	794	850	3,039
Customer reception	91	106	126	117	440
Protection of customers' privacy	25	83	82	56	246
Others	84	99	134	73	390
Total	2,239	2,251	2,699	2,334	9,523

(as of March 31, 2006)

	Fiscal 2006
	Apr-Jul, 06
Sales and solicitation	1,521
Policy administration and maintenance	1,973
Claims handling	2,914
Customer reception	327
Protection of customers' privacy	79
Others	2,632

Total	9,446
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(as of July 31, 2006)

2. Outlines of Complaints by Category

(1) Sales and Solicitation Service

Among complaints related to sales and solicitation, most concerned explanation of policy terms and conditions, such as insufficient explanation on material information prior to signing or on information that is potentially adverse to policyholders, followed by complaints about policy renewal. While sales and solicitation should naturally be conducted thoroughly in compliance with relevant laws, we, as a company that puts the first priority on the customers' view, further intend to carry out our responsibility to provide sufficient explanation to customers so that they fully understand policy clauses before signing a contract. To this end, we will improve explanation and make materials easier to understand with due consideration to suggestions and opinions from customers and external experts.

(2) Policy Administration and Maintenance

Among complaints about the policy administration and maintenance service, most pointed out that the policy certificate either had not been promptly delivered or contained incorrect information, and complaints about policy cancellation process followed. The Company will review the system for policy administration and policy data maintenance in a bid to prevent such complaints in future with its intention that policies should be checked more closely in the process of preparation and that addresses and other contact information of policyholders of long-term insurance should be regularly reconfirmed or updated.

(3) Claims Handling

Among complaints related to claims handling, most stemmed from the less than desirable response by our staff - that the explanation provided was too insufficient to agree, or that explanation orderly and easy to understand was desired. The second largest sort is of complaints about "recognition of damages," including denial of claim and details of payout.

Claims should not only be treated in a fair and equitable manner in accordance with policy clauses, but we should also explain the basis of our determination to pay or not pay so that each customer understands and agrees. The Company is making efforts to enhance such preparedness in response to customers and become more professional in this regard.

In addition, the Company is bettering the system for prompt claims handling such as by providing easier instructions to customers on filing each and every payable claim and on filing all necessary documents.

(4) Customer Reception, Protection of Customers' Privacy and others

The Company has received many other complaints, including those about bad behavior or manner of employees, leak of customer information, criticism about the very fact of the administrative measures, and concerns about possible negative effects of the administrative measures.

We all at the Company pledge ourselves to seek the way to finding solutions for such matters as subject to customers' complaints by responding to each customer faithfully, smoothly and properly with a sincere explanation easy to understand so that each customer understands and is satisfied.