

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 third report on the current status of implementation of the business improvement plan. The Company had 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.

For more updated information about specific measures taken under the plan, please refer to Attachments 1 and 2.

Attachment 1: Major Measures Taken under Business Improvement Plan

Attachment 2: Improvement and Strengthening of Claims Payment Administration System

1. Improvement and Strengthening of Corporate Governance

1.1 Operations in Place and Recent Progress of Business Improvement Plan Monitored and Reviewed by Audit Committee

The Audit Committee met for the second time on October 17, 2006. At the meeting, the committee received an internal audit report, and then the Corporate Quality Control Department presented a report on monitoring results of the operational administration system, recent progress of the business improvement plan, etc. The members of and advisors to the committee, particularly outside directors, discussed actively in response to these reports.

Opinions raised there include as follow: “Judging from the summary of reported incidents of misconduct, it is significant that an incident of misconduct was found, in so many cases, with a clue originated by customer’s complaint or inquiry and so it is important to listen carefully to customers and analyze what they say and what the situation is like.” “In analyzing complaints, both the number of cases and what they matters there should be focused on. A quick action is vital in case where any substantial measure is additionally required.” “Taking this opportunity, the employees should be surely reminded that the solicitation rules, such as those prohibiting filling an application form and affixing a seal on behalf of an applicant, are strictly observed and strongly advised to be aware of compliance requirements.” “Recent court decisions should be referred to in interpreting policy clauses, and a determination should not be constrained by the conventional standards and concepts in a bid to make an appropriate decision.” The committee agreed that these opinions should be reflected in incoming measures for improving operational systems.

1.2 Operational Administration System Monitored by Corporate Quality Control Department

The Corporate Quality Control Department was newly established as of September 1, 2006, and conducted a monitoring campaign in every process of the insurance business. It concentratedly paid attention to written explanations at the points of sale to applicants and claims payment to claimants because most opportunities to have contacts with customers arise on such occasions. In respect of the application forms of major insurance products offered to the consumer public, the department requested an institution specialized in consumer programs to assess the forms while a survey was conducted by interviewing consumers. Now the department is on the way to listing the issues pointed out and classifying them for solution. In addition, based on the evaluation obtained from the institution and the findings of such interview with consumers, a review was made for the forms of “Insurance Claim Statement” and “Notice of Eligible Claims,” which are sent to a policyholder involved in an accident.

1.3 Strengthening Communications between Management and ‘Front-Line’ Employees and between MSI and Agents

The “Meet the Management” campaign is ongoing to enhance communication between management and front-line employees. The chairman, the president and other management members have visited 83 departments and branch offices in Japan and talked with front-line employees there about operational issues and solutions thereto. Some front-line employees later raised concrete proposals based on discussions made on these occasions. The proposals are reviewed at headquarters and management to be selected and incorporated in a “new group vision,” which is under preparation and will be finalized by March, 2007 or in the “*Tsukuru Kawaru* (Create –and Change) Project,” which aims to create a new corporate culture.

Meanwhile, the Company issued response to the suggestions raised at the monthly meeting with the MSA (an organization of the Company’s top-tier agents in Japan) Secretariat held in August 2006. The Company specifically referred in the response to “plain-and-easy-to-understand product development,” “raising awareness of employees in having better manners and enriching the educational programs” and other suggestions and expressed that it would take them up in incoming measures for business improvement.

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

2.1 Dramatic Review and Improvement of Claims Payment Administration System

(a) Personnel Reinforcement in Claims Handling Departments

In accordance with the guideline adopted for deploying workforce to the claims handling division by management in August 2006, it is determined that the Company will assign 178 persons additionally to respective claims handling departments effective November 1, 2006. As a result, new staff aggregates to 218 people in this area for the period from September to November. By further increasing workforce, our claims handling service will be more accountable to policyholders in claims handling services and perform its duty better.

(b) Updating and Strengthening of Education System for Employees

New personnel above referred to in (a) is to be intensively educated for about a month to learn basic knowledge and tips required in claims handling before assignment to a Department. Teaching staff was also reinforced with five instructors effective September 1 and October 1, 2006, expanding to a fifty-member team for claims handling. An educational program of practical knowledge on disease and medical care required for claims handling was newly established, and a correspondence course was opened thereunder in October 2006. The course runs twelve months and is programmed with monthly test to help trainees keep learning according to a schedule. For the first year, all employees at services centers of the fire and miscellaneous product lines are required to take the course, and employees newly assigned there will follow next year and onwards.

(c) Integration of Claims Handling Services of Whole-Life Medical Insurance

A long-term medical service center was set up as of October 1, 2006. Claims handling services of whole-life insurance, which used to be administered separately at service centers of fire and miscellaneous product lines located across the country, were concentrated to and integrated at this newly established center. The Company now provides highly professional, fair and equitable services from the center.

(d) Continuous Disclosure about Claims Payment, etc.

The Claims Payment Examination Council commenced its examination activity with checking claims payments of third sector products on September 1, 2006. Its scope was extended to cover automobile and other non-third-sector claims in October. The council will disclose regularly the number of cases examined with a summary of specific findings.

The Company also continues to disclose outcome of claims in a timely and appropriate manner and moreover, will disclose customer complaints and objections raised regarding claims handling as well as examples of claims denied as ineligible pursuant to policy clauses.

2.2 Dramatic Review and Improvement of Product Development System

The Company established the Product Division on October 1, 2006 to aim a smoother and firmer cross-product-line cooperation in improvement of product reform and product development operation. The Division, in its function, develops and formulates product improvement principles and decides to improve or retire a product in accordance with the principles in cooperation with the claims handlings and sales divisions.

3. Improvement and Strengthening of Policyholder Protection and Policyholder Benefits

3.1 Strengthening of Compliance Education to Employees and Agents

As part of strengthening compliance education to employees, the Compliance Department sends not only its staff to give a lecture to employees in a training session, but a district manager to a general managers' meeting at the bloc divisions in his/her district and deliver compliance guidance there. Meanwhile, as a compliance education tool for agents, "Compliance News" was launched and will be issued regularly.

3.2 Dramatic Review and Improvement of Complaints Response and Handling System (Council on Promotion of Customers' Viewpoint Met)

The Council on Promotion of Customers' Viewpoint held the first meeting on October 13, 2006. The council discussed "complaints regarding claims handling," which had scored highest in the complaints received for both fiscal 2005 and 2006. Members exchanged their opinions regarding content of Insurance Claim Statement and reception manners of employees, and the council is collectively making a proposal based on the discussion to submit it to the Board of Directors.

4. Improvement and Strengthening of Legal Compliance System

4.1 Reviewing Appropriateness in Determination of Incident as Misconduct

The Misconduct Examination Council has been opened for reviewing appropriateness in determination of incident as misconduct since October 2006, with two or more lawyers invited thereto. The council re-examines whether the Compliance Department conducted a sufficient investigation and whether its determination is appropriate. Furthermore, if more investigation and/or discussion deem necessary, the council may, with advices from two or more lawyers, decide whether to extend the investigation and whether endorse or reverse the determination.

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improvement objective		approach and measures		status
appropriate claims handling	claims payment administration	principles	Principles on Upgrading Claims Handling System for Appropriate Payment formulated [Aug]	
		new units and programs	Claims Handling Examination Dept. established (cross-checking, monitoring and supervising claims handling services) [Sep] Claims Payment Examination Council established (external check by lawyer, consumer leader, doctor and other experts) [Sep] → Examination started for third sector claims in Sep, auto, fire and other claims in Oct (43 cases examined in total as of Oct. 16) Claims Handling Consulting Section opened (help desk for general inquiries and consultation about claims payment) [Sep] Claims Payment Objection System established [Sep] Long-Term Medical Service Center established (claims handling consolidated, enhance professional and equitable services)[Oct]	
		personnel	Workforce increasing in claims handling (218 persons being deployed from Sep to Nov, more workforce planned by next spring)	
		education	Standard education system formulated Education staff reinforced (45 persons assigned in Apr, 5 assigned in Sep and Oct) Education course of diseases and medical care launched for acquiring practical knowledge and use in claims handling	
		systems	Car accident registration and under-payment warning enhanced Automatic multi-claim payment system set up [Sep] Building systems for eligible claim notification, eligible claim inquiry system for claims receiving desk staff (under development)	
	product development	principles	Product Development Guidelines governing product development and retirement revised [Sep]	
		new units	Product Division established (ensures and smoothens cross-product-line improvement in designing and control) [Oct]	
		survey	Conducting post-sale customer survey [Sep and onwards]	
		product	(Product Division planning product revision after expiry of business suspension period)	-
	Policy interpretation in claims handling	denial and payment error reviews	Standard Policy Interpretations, Criteria in Determination of Ineligible Claim, etc. prepared [Sep]	
		Claims Handling Examination Dept. making on-spot examination [Sep and onwards] Monthly payment check (possible error cases automatically retrieved among claims closed), findings review [Sep and onwards]		
policyholder protection and benefits	complaints response	principles	Complaints Response Guidelines” formulated [Sep]	
		new units	Customer Service Dept. established (gathers and analyzes complaints) [Sep] Council on Promotion of Customers' Viewpoint established (analysis report to mgmt, remedy advice to Board)[Oct] Claims Handling Consulting Section opened (help desk for general inquiries and consultation about claims payment) [Sep]	
	regal compliance	Compliance Enhancement Month campaign [Aug-Sep] Strengthening compliance education [Aug and onwards] Periodical “Compliance News” launched [Oct and onwards] Performance evaluation systems linked to compliance [Oct]		
corporate governance	corporate governance	Audit Committee established (outside directors holding majority) [Sep] → 1st meeting on Sep 19, 2nd meeting on Oct 17 Nomination Committee and Remuneration Committee increased outside directors to majority [Sep]		
	reporting of routine operations	Corporate Quality Control Dept. established (monitors and reviews appropriateness in routine operations) [Sep] New Vision Promotion Division established (“new group vision” formulated) [Aug] Closer communication between mgmt and front-liners [Jul and onwards] Meet-the-Mgmt at 83 office in total as of Oct 20		

tighter internal audit

Internal Audit Dept. substantially increased audit staff (66 → 97 persons) [Sep]
Supervisory Section established (examines notices of internal audit findings) [Sep]

Attachment 2 **Current Status of Improvement and Strengthening of Claims Payment Administration System**

The Principles on Upgrading Claims Handling System for Appropriate Payment were formulated for improvement and strengthening of the claims payment administration system, based on which the Company has taken measures for (1) personnel reinforcement, (2) establishment of units and programs and strengthening of organizational functions, (3) review and revision of internal rules, operation manuals, forms and vouchers, (4) computer system development and (5) strengthening of education.

1. Formulation of Principles

The Principles on Upgrading Claims Handling System for Appropriate Payment were formulated for the purpose to early restore customers trust based on an idea that the Company should review dramatically the claims payment administration system to restructure it into one better-prepared for policyholder protection, etc. and properly manage it.

2. Specific Measures Taken for Improvement and Strengthening

(1) Personnel reinforcement

It was determined that 178 persons should be additionally assigned to the claims handling division effective November 1, 2006, and as a result, workforce thereof will have increased 218 persons in total during the period from September to November. Personnel to be deployed effective November 1 are scheduled to take a training session for about a month prior to the assignment in order to learn basic knowledge and tips required for claims payment services. The Company continuously increases competent personnel and makes efforts to be accountable to policyholders in claims handling and perform the duties to pay appropriately for claims.

(2) Establishment of units and programs and strengthening of organizational functions

In a bid to be sufficiently accountable for claims handling as well as monitor claims payment performance and ensure appropriate payment, the Company newly established units and instituted programs as follows:

(i) Establishment of Claims Handling Consulting Section (September 1, 2006)

The Claims Handling Consulting Section was newly established within the Customer Service Department to work as a help desk to receive customers' general inquiries and complaints and provide consultation to them in respect of claims payment services. It originally started with 12 dedicated employees, and will be a 15-member team effective November 1 to ensure sufficient explanations to customers.

(ii) Establishment of Claims Handling Examination Department (September 1, 2006)

The Claims Handling Examination Department was newly established, separated from the claims handling division, and, in its function, investigates, analyzes, reviews appropriateness of claims

handling operation . The department will start sending its staff to all services centers in the country for on-spot examination and, in case where it determines that any supplementary action or correction of transaction and/or remedy are necessary, follow up such a case.

(iii) Establishment of Claims Payment Examination Council (September 1, 2006)

The Claims Payment Examination Council was established, comprised of third parties such as lawyer, consumer group leader and medical professional. The council makes pre-final examination on selected serious cases of third sector and automobile claims which are preliminarily determined as ineligible. It also re-examines such cases where a claimant raised an objection against the determination notified by the Company.

(iv) Institution of Claims Payment Objection System (September 1, 2006)

The Claims Payment Objection System was instituted to respond appropriately to a claimant raising an objection in case where the Company once notified him/her to the effect that the claim was determined ineligible. The Company retained a lawyer to receive an objection and started notifying such claimants to the effect.

(v) Integration of claims handling of whole-life medical insurance (October 1, 2006)

The Long-Term Medical Service Center was established to concentrate and integrate claims handling operation thereunder. The Company will increase professional expertise in whole-life medical insurance at the center and provide fair and equitable claims payment service.

(3) Review and Revision of Internal Rules, Operation Manuals, Forms and Vouchers

Various sorts of internal rules, operation manuals, forms and vouchers were reviewed and revised. Particularly, the Standard Policy Interpretations and the Criteria in Determination of Ineligible Claim were prepared to avoid an employee in the claims handling division from misunderstanding in interpretation of policy, prevent claims handling service from varying from an employee to another and thereby secure fairness, transparency and appropriateness in the service.

(4) Computer System Development

The Company has been adjusting and improving the computer programs to prevent failure to pay for extraordinary and incidental expenses at the point of payout under the main clause by enhancing the functions of the automobile accident registration and the non-payment warning at the point of payment as well as bettering preciseness of retrieving and extracting data to be used in the post-payment monitoring. Specifically in case where two or more insurance clauses, such as a combination of bodily injury liability and passenger medical payments clauses, may be applicable to an accident, an accident report once registered under a clause of policy is automatically registered under the rest of applicable policy clauses within the system program introduced in September. Other than those developments for such payment failure prevention, the Company is also building programs, including one preparing a notification of eligible claims and sends it to the reported policyholder and one facilitating inquiry of eligible claims in detail at the claim receiving desk while responding to a reporting policyholder.

(5) Strengthening of Education

The Company first built a standard education system for employees in the claims handling division and develops human resources systematically based on it. A correspondence course was opened in October 2006 within the education program launched for acquiring practical knowledge of diseases and medical care to use in claims handling.

In addition, 45 instructors were assigned as teaching staff for the claims handling division in April 2006, and the team was reinforced with 5 more persons in total in September and October as part of strengthening the employee education

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Attachment 3 Under-payments for Incidental Expenses and Inappropriate Denials of Third-Sector Whole-Life Medical Claims

1. Recent Progress of Follow-up of under-payments (as of October 19, 2006)

Investigation has been conducted for cases of under-payment or failure to properly pay extraordinary and incidental expenses pertaining to those claims paid during the period from April 2004 to June 2005. As a result, 45,753 cases or 97.7 percent of 46,810 cases once found not yet paid fully have now been duly settled as of October 19.

The Company continues to make efforts to find those deserving customers who are unavailable for contact due to moving or any other reasons as well as make a settlement without delay with those customers under the payment process.

2. Recent Progress of Inappropriate Denials of Third-Sector Whole-Life Medical Claim (as of October 19, 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. As a result, 858 cases or 92.6 percent of 927 cases identified as inappropriate non-payment have been duly settled as of October 19, 2006.

Furthermore, the Company is conducting a thorough investigation and examination of third-sector claims once denied, covering such claims made as early as during fiscal 2001. The Company will announce the results there of as they became available.

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