

To whom it may concern:

Mitsui Sumitomo Insurance Co., Ltd.

**Findings in Review regarding Third-Sector Claim Denials
and
Improvement and Transformation of Claims Payment Administration System**

Mitsui Sumitomo Insurance Co., Ltd. (“the Company”) (President & CEO Toshiaki Egashira) submitted a report on findings in the review conducted regarding its past denials of third sector insurance claims, to the Financial Services Agency of Japan (“the FSA”) under the FSA’s order dated July 14, 2006 calling for such report. Here is an outline of the report as set forth below.

1. Findings in Review regarding Third-Sector Claim Denials

- 1.1** The Company reported on June 21, 2006 that 927 cases of inappropriately denied claim were found among the claims made during the four-year period from April 2002 to March 2006. The Company has conducted another review, now extending the period covered to the five-year period from July 2001 to June 2006, on whether each denial determination was appropriate. As a result, the number of denials identified as inappropriate amounted to 1,140, an increase of 213 from previously reported 927. The breakdown by reason for denial and kind of insurance is as follows:

(Number of cases)

Reason for denial	Number of claims eligible						Total
	Medical	Cancer	Income Protection	Medical expenses	Medical care	Others	
Exclusion clauses	56	0	39	5	0	0	100
Policy invalid for fraud	0	0	0	0	0	0	0
Policy cancelled for misrepresentation prior to contract	249	0	6	0	2	0	257
Policy cancelled for misrepresentation during contract	0	0	0	0	0	0	0
Policy cancelled for other material breach	0	0	0	0	0	0	0
Claim not covered	579	0	144	20	2	0	745
Others	26	0	8	4	0	0	38
(Total)	910	0	197	29	4	0	1,140

< Reasons for increase >

A. Additional claims reviewed

The Company had previously reviewed the appropriateness of denial determinations for such

reasons as “illness prior to the intended effective date of coverage” and “breach of duty to provide proper health condition statement” as pointed out by the FSA in its last on-site examination, covering claims made during the four years starting April 2002. The most recent review extended the period covered to five years.

B. Denials once determined appropriate reexamined in light favorable to customers

The Company reexamined its earlier findings as appropriate made during the previous review. This time, for example, the Company even reexamined cases where no claim has been filed, based on customers’ conditions as ascertained from accident notices initially filed, as to whether the Company appropriately did not pay.

1.2 Of the 1,140 claims now identified, 870, or 76.3 percent, have been settled as of October 27, 2006. In respect of the 927 cases as previously reported, 865, or 93.3 percent, have now been settled.

2. Progress of Improvement and Transformation of Claims Payment Administration System

The Company recognizes that timely and appropriate claims payment service is a function that is indispensable, fundamental and of primary importance in the insurance business. The Company has been conducting a dramatic review on its claims payment administration system and is taking measures to improve the system in accordance with the business improvement plan submitted to the FSA on July 21, 2006.

Starting the total reconstruction of the management structure by newly establishing the Audit Committee, the Company has provided for an additional line besides the existing executive line, so that important subjects affecting customers, such as inappropriate non-payments on third-sector claims, are properly proposed or reported to the management.

Upon this framework foundation, the Company has prepared a new system as set forth below, making progress as intended in improving the sales system and launching a multi-step checking system in order to prevent a recurrence of inappropriate claim denials.

2.1 More appropriate administration regarding claim denial

A. Claim denial criteria clarified and enforced

To ensure appropriateness in determining a claim as ineligible for reasons such as illness prior to the intended effective date of coverage and breach of duty to provide proper health condition statement, the Company has issued the Criteria in the Determination as Ineligible Claims, the Standard Policy Interpretations, and the Diseases Manual, and are now training employees in an effort to enforce them properly.

B. Tightening supervision on claim denial determination

Recognizing the gravity of a claim denial determination, the Company formulated the Rules of Authority to Deny Non-marine Claims. The rules delegate much of authority previously delegated to a manager of a service center now to a general manager of a claims

department, and thus the propriety of each determination is now double-checked by both a manager and a general manager. Also, denial determinations subject to a general manager's approval, which are now transmitted in writing, will be electronically handled by a new system for submitting and approving denial determinations, expected next January. The Company will make use of the new system in combination with the existing system introduced last October that stores image data of claims-related written documents, and improve the propriety of claim determinations made by the executive line.

C. Preventive measures against inappropriate claim denial

Thoroughly revising the procedures and formats in connection with the claims payment administration, the Company has built up a system that preemptively eliminates possible causes of inappropriate claim denial.

a. Change of underwriting procedures

In respect of whole-life medical insurance, policies had been written on decisions based on an agent's decision and without a written diagnosis of medical professionals. The change in procedures requires such diagnosis before determining whether to write a policy and/or attach any conditions in case where the customer has any medical history.

b. Preparation of rules regarding correcting notice/representation

The Company provided for the procedures for cases where a customer wishes to add to or correct his/her own earlier statements made at the time of application for a policy.

c. Revision of condition statement form

The Company revised the form of condition statement for whole-life medical insurance into a question-and-answer format based on advice from medical professionals with expertise in medical insurance so that customers easily understand what to state in the form.

d. Accountability performance of agents

The Company issued the Solicitation Manual for agents, containing cautions, underwriting flow and prohibitions applicable at the solicitation stage. The Company also issued the Representation Guide Materials on whole-life medical insurance that inform agents of the importance and cautions regarding customer representation.

2.2 Strengthening system for supervision and investigation on claim denials

A. Setting up units for third-sector claims only and enhancing investigation function

Towards the provision of uniform third-sector claims payment services, The Company established the Medical Support Office staffing 9 employees and the Long-term Medical Service Center staffing 18, within the Fire and Casualty Claims Department.

The Medical Support Office, with cooperation from resident advisory doctors, makes determinations on each and every claim for which a local service center considers denial for illness prior to the intended effective date of coverage, and on whether to submit such case to the Claims Payment Examination Council for approval. The Office is also responsible for

employee education on medical knowledge and medical expense insurance.

The Long-term Medical Service Center not only administers cancellation for customer misrepresentation prior to contract but alone handles each and every whole-life medical claim. The Center thus assures proper and uniform claim handling services, such as through centralized investigation and eligibility determination.

B. Claims Handling Examination Department established for improved monitoring

The Company established the Claims Handling Examination Department, consisting of 22 persons, for the purpose of better post-determination review on claim denials. The Department conducts monthly inspection and on-site examination of service centers, and thereby examines the propriety of determinations on claims as ineligible, etc. The Department reports its findings of these examinations to the Audit Committee and the Board of Directors separately from the reports by the executive line, thus functioning as internal check on the claims handling division as well.

2.3 Introducing external monitors on claim denials

A. Establishing Claims Payment Examination Council

The Company established the Claims Payment Examination Council consisting of standing members of a lawyer, a consumer group leader, a medical expert, etc. from outside the Company, and sub-members of employees of the Company from related departments. The Council started its examination activity last September.

While the Council enhances appropriateness of determination as customer misrepresentation, illness prior to the intended effective date of coverage, etc. by these outside experts' examination, it also improves the transparency of the claims handling procedures by disclosing the results of the examination. Having examined 120 cases, the Council is already on the track. The Company plans to compile a casebook out of cases examined by the Council, so that the shared know-how will supplement the expertise of each employee earned from experience.

B. Complaints and voices from customers

The Company now recognizes that customer complaints are critical information that helps improve its claims payment services. The Company therefore established the Customer Service Department staffed with 30 employees and responsible for administering each and every customer complaint, and the Council on Promotion of Customers' Viewpoint which is as an advisory body to the Board of Directors with a majority of members from outside the Company. In accordance with suggestions raised at the first meeting of the Council, the Company is now analyzing complaints about claim denial, which is the most frequent cause of complaints, and will reflect customers' opinions in the ongoing effort of business improvement.

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