

November 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 fourth report on the current status of implementation of the business improvement plan. The Company submitted the plan to the Financial Services Agency on July 21, 2006, and has been taking specific measures thereunder since then. Here is an outline of the report as set forth below.

1. Customer Survey and Agent Surveys Conducted

1.1 Customer Survey Conducted

The Company commenced a customer survey in November 2006, enclosing an answer form with a policy certificate of automobile or fire insurance. The answer form questions a policyholder whether or not the application form and the policy certificate are easy to understand and ask for any comment or suggestion about the application process. The Company will analyze returned answers and reflect the customers' voice in revising application forms and policy certificates and for other improvements.

1.2 Reminder Notice of Whole-life Medical Insurance and Health Representation

The Company now reminds policyholders, with a “Notice Regarding Your Policy” mailed annually to each policyholder, of the terms and conditions of the relevant policy and notifies them of how to correct any deficiency in health representation made upon signing.

1.3 Agent Survey

For the purpose of making automobile insurance easy for customers to understand, the Company conducted a survey with approximately 100 product monitors selected from the organization of our top-tier agents in Japan, and obtained opinions in various respects. The Company will reflect the returned answers, particularly, suggestions on desirable coverage easy for customers to understand, in product development.

2. Prevention of Third-sector Claim Non-payments

2.1 Claims Payment Services Centralized

The dedicated sections newly established effective October 1, 2006, as part of strengthening the claims handling administration system are duly working. 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. 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 Company will improve the quality, uniformity and propriety of its claim handling services through centralized investigation and eligibility determination.

2.2 Payment Examination Council in Work

The Payment Examination Council embarked on its work on September 1, and has examined 136 cases as of October 31. Propriety of determination regarding prior illness and customer's misrepresentation has improved through checking by the external expert members, and the council is now on the right course towards assuring proper claim examination. The Company plans to compile a casebook of third-sector claims out of cases examined by the Council by the coming year-end, so that the know-how on third-sector claims, as shared throughout the Company, is accumulated and further developed.

3. Assuring Appropriate Claims Payment Services

3.1 Monitoring by Claims Handling Examination Department

The Claims Handling Examination Department monitors the appropriateness of the claims handling services through both monthly inspection on cases handled that are accessible online, and on-site examination at local service centers. 1,414 claims have been covered by monthly inspection as of October 31, and 26 services centers have been examined on-site during the period from October 24 to November 20.

3.2 Contacts to Claims Handling Consulting Section and Feedback for Business Improvement

The Claims Handling Consulting Section was established on September 1 with 15 dedicated employees, responds promptly and properly to customer contacts, and has received 1,440 contacts of inquiry, consultation and complaint as of November 20. The received complaints are analyzed by the Customer Service Department. Issues touching on business operations thus screened out are reported weekly to responsible officers and relevant departments cooperate in ascertaining the problems and discussing remedial actions.

4. Strengthening of Internal Audit and Compliance Systems

4.1 Internal Audit System Being Continuously Strengthened

The Company hired two mid-career employees with prior experience in internal audit of a financial institution effective November 1. The Company also holds training sessions for all internal auditors to improve the skills of the internal audit staff.

4.2 Monitoring Office Operation by Compliance Department

The Company constantly monitors the operations of sales departments and branches with regional general managers for the Compliance Department. The Company will duly implement the action plan adopted for each region covering the second half of the fiscal year. (The plans cover a total of 81 departments/branches and 127 sections.)

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Attachment **New Sections Dedicated to Third-sector Medical Insurance Products**

The Medical Support Office and the Long-term Medical Support Center were newly established within the Fire and Casualty Claims Department effective October 1 in order to prevent inappropriate non-payments of third-sector medical claims. The new units offer proper and uniform third-sector claims handling.

1. Medical Support Office

1.1 Reconfirmation regarding “Prior-illness” Claims

With cooperation from resident advisory doctors, the Medical Support Office examines, prior to notice to customers, each and every claim that a local service center has considered as ineligible under the exclusion clause for illness prior to the intended effective date of coverage.

< Examination results as of November 20, 2006 >

Prior-illness applicable	95 claims
Prior-illness inapplicable	7 claims
Further investigation necessary	21 claims
Forwarded to the Claims Payment Examination Council for possible misrepresentation	1 claim
Under examination	13 claims
(total)	137 claims

1.2 Better Education and Training regarding Third-sector Insurance Products

The Medical Support Office is solely responsible for administering medical insurance, and is now making efforts to improve the skills of the staff engaged in medical insurance by giving them streamlined education on medical knowledge and assure proper and uniform claims payment services. An on-line educational program on medical knowledge is made available effective October 2006 to all employees who handle fire and casualty claims.

2. Long-term Medical Service Center

2.1 Centralization of Whole-life Medical Claims Handling Services

The Long-term Medical Service Center alone handles each and every whole-life medical claim. Effective October 1, 1,618 claims were transferred from local service centers across the country. As of November 20, the Center has received 3,543 claims, inclusive of the 1,618 mentioned above, and honored 1,599 .

2.2 Instruction and Guidance regarding Misrepresentation Investigation and Cancellation

The Long-term Medical Service Center assures proper and smooth handling of policy cancellation due to customer's misrepresentation prior to contract by investigating events up to signing and finding whether misrepresentation occurred. The Center now administers cancellation of 18 policies found

by the Third-Sector Claims Examination Sub-committee since October 1 to have involved misrepresentation warranting cancellation of policy.

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