

February 21, 2007

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) today submitted the seventh report on the current status of implementation of the business improvement plan (“the Plan”). The Company had submitted the Plan to the Financial Services Agency (“FSA”) on July 21, 2006, and has been taking specific measures thereunder since then.

The Company has already strengthened its internal administration systems, increasing internal auditors and improving various operations through analysis of customer complaints. The Company will continue to commit itself to these initiatives, and will thereby further improve customer protection and convenience.

Through these and other efforts, the Company will seek to improve its business quality and restore customer confidence.

1. Further strengthening of the internal administration systems

1.1 Further strengthening of the internal audit system

The Company has increased staff for its internal audit division from 66 to 98 since formulating the Plan, thus upgrading its audit capabilities. The division has also rebuilt its systems by conducting education programs designed to improve the methods and skills of internal audit so that the system will operate at a higher level.

Also to this end, the Company is encouraging the internal audit staff to acquire objective qualifications. So far, four have qualified as financial internal auditors, another four as certified internal auditors, and yet another four as qualified internal auditors.

1.2 Group-wide centralization of complaint handling (extended coverage to overseas offices and domestic group companies)

The Customer Service Department has centralized the management of customer complaints wherever originated, including those at overseas offices. Underlying is the Company’s recognition that customer complaints are “key information useful for improving our operations.” In addition, preparation is under way to cover our group companies within, Japan effective coming April.

Thus, the entire Mitsui Sumitomo Insurance Group, whether within or outside Japan, will have in place the systems for properly handling customer complaints and reflecting customers’ voice in improving business operations.

1.3 Strengthening of the head office's risk management system for overseas offices

The Company has designated two full-time supervisors to reinforce the risk management at overseas offices.

In addition, the Company will establish within the International Department an independent team responsible for risk management at overseas offices, effective April 1, 2007.

2. Further strengthening of the claims administration systems to prevent underpayment

2.1 Further staff reinforcement

The Company had increased staff for its claims handling division by Ann aggregate of 218 by November 2006. The Plan had originally set forth an increase of 200.

The Company has continued to reinforce the division and will have invested a total of 299 employees once additional assignments become effective March 1, 2007.

2.2 A preventive system against failure in payment

The Company has installed and launched the following systems for the purpose of ensuring appropriate customer explanation regarding relevant claims. The systems help make sure that customers are informed of the details of payout on their claims.

- (1) A system that helps list incidental and/or eligible claims for each customer under relevant policy,
- (2) A system that describes the payout amount for each item of eligible claims on a postcard notification (to be in full operation coming March), and
- (3) A system that produces a notice of withdrawal or refusal to be mailed to customers who have withdrawn their claims or refused to receive the payout.

3. Measures taken to monitor routine operations and secure their propriety

3.1 Propriety monitoring of routine operations by the Audit Committee

The Audit Committee was established for the purpose of monitoring propriety of routine operations and making recommendations to the Board of Directors. The Committee has met six times so far and functioned as planned, confirming the status of implementation of the Plan and monitoring the approach towards restoring confidence in the Company, both from an external viewpoint.

3.2 Monitoring of routine operations by the Corporate Quality Control Department

The Corporate Quality Control Department was established for the purpose of monitoring the propriety of various routine operations and developing necessary solutions. The Department has sponsored a seminar on preparation of documents for customers, customer monitor meeting and other gatherings, inviting as presenter a consumer lifestyle counselor. The Department continues to collect comments from outside the Company in search of customer explanations yet easier to understand.

3.3 Examination of propriety of claims payment by the Claims Handling Examination Department and the Claims Payment Examination Council

The Claims Handling Examination Department was established for the purpose of monitoring the propriety of claims payment. The Department monthly examines the results of post-payment self-inspection conducted by each service center to detect any failure to properly pay claims, thus functioning to prevent payment failures.

The Claims Payment Examination Council was established for the purpose of examining the propriety of determination of claims as ineligible with the help of external experts. The Council regularly meets and has been functioning as planned, enhancing the accuracy of ineligibility determination for illness prior to the intended effective date of coverage or failure to provide proper health condition statement, through accumulation of cases examined by external experts.

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Attachment 1 **Examination by the Claims Payment Examination Council**

The Claims Payment Examination Council commenced its examination activity with respect to third-sector claims on September 7, 2006 and automobile and other non-third-sector claims on October 4, 2006.

The Third-sector Claims Examination Sub-committee met seven times and the General Claims Examination Sub-committee for non-third sector claims four times in January. The Sub-committees collectively examined 72 cases and concluded that 39 of them were eligible and 33 ineligible.

Number of cases determined ineligible by the Claims Payment Examination Council (as of January 2007)

Claims subject to examination	Reasons for ineligibility determination	Number of claims
Third-sector claims	(1) cases where a relevant policy is to be cancelled because a material fact that should have been disclosed at the time of contract was either intentionally omitted, omitted by gross negligence or disclosed not truthfully and because a causal relationship existed between the underlying illness not properly disclosed and the claim	19 claims
	(2) cases where a claim is ineligible because the underlying illness is established to have occurred prior to the effective date of the relevant policy (prior-illness) and, by deliberate examination based on facts confirmed, to have since continued	0 claims
	(3) other reasons (such as breach of duty to notify the insurer, policy invalidated due to fraud and policy canceled due to a material fact)	0 claims
Automobile, fire and personal casualty claims	(1) cases where the death of an insured has no causal relationship with the accident or was caused by driving under influence of alcohol	9 claims
	(2) cases where an accident was intentionally caused by the relevant policyholder	3 claims
	(3) other reasons (such as breach of duty to notify the insurer and breach of duty to cooperate in investigation)	2 claims
	(total)	33 claims

Attachment 2 **Failure to Properly Pay Claims of Extraordinary Expenses Coverage and Inappropriate Denials of Third-sector Whole-life Medical Claims**

1. Update on the follow-up services concerning incidental claims left unpaid

The Company has conducted investigation on claims first paid during the period from April 2002 to June 2005 with respect to which extraordinary and incidental expenses remained unpaid by error. As of February 20, 2007, the Company has completed the follow-up payments due in 46,260 cases (or 99.0%) out of 46,260 identified.

2. Update on the follow-up services concerning unpaid incidental claims identified in the course of additional investigation

The Company concluded the investigation regarding failures to pay claims for extraordinary and other incidental expenses by error, and submitted a report on this matter to the FSA pursuant to its order dated November 17, 2006 calling for such report. The Company is now paying relevant customers the amounts due that have come to light through the investigation. The Company will announce the aggregate number and amount of failed payments once supplemental payments due are completed.

3. Update on the follow-up services concerning inappropriate denials of third-sector whole-life medical claims

The Company has investigated and examined the appropriateness in determination in respect of the claims denied during the period from July 2001 to June 2006. Based on the result, the Company has completed the follow-up payments due in 1,129 cases (or 99.0%) out of 1,140 identified as of February 20, 2007.