

April 20, 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, Chief Executive Officer, Toshiaki Egashira) today submitted the ninth report on the current status of implementation of the business improvement plan (“the BIP”). The Company had submitted the BIP to the Financial Services Agency (“the FSA”) of Japan on July 21, 2006, and has taken specific measures thereunder since then.

Being duly implemented under the BIP, the specific measures are now working in place. Furthermore, New Challenge 10 (“NC 10”), a medium-term management plan, was newly formulated for the coming four years beginning from fiscal 2007. NC 10 will follow the BIP in improving and strengthening the systems of management, claims payment administration, etc., and the Company will make further efforts to enhance corporate quality along the line of NC 10.

1. Effective internal administration

1-1 Monitoring of operations by the Corporate Quality Control Department

The Corporate Quality Control Department, which was established for the purpose of monitoring the propriety of various routine operations and developing any necessary solutions, regularly monitors the opinions of consumer public about various documents in actual use. Particularly in March it made interviews with respect to the forms of “Insurance Claim Statement,” “Notice of Eligible Claims,” “Notice of Health Condition Statement,” etc. and acknowledged informative comments therefrom. These comments will be reflected in revising documents to customers in order to make them yet easier to understand.

1-2 Further enhancement of the internal auditing system

Seven more auditing staff were assigned to the Internal Audit Department effective April 1, 2007. This reinforcement made staff of the department 105 in total, almost doubled from 66 as of July 1, 2006. These internal auditors are devoted to increasing their capabilities. They have received five lectures of training from external experts on the themes of specialized knowledge necessary in their job since September 2006. As a result, twelve of them are qualified specialists, including two internal financial auditors qualified in March.

1-3 Further strengthening of the claims payment administration

1-3-1 116 persons were assigned additionally to the claims payment division effective April 1, 2007, totaling the reinforcements to 415 persons since September 2006.

1-3-2 The Claims Payment Examination Council, in which the external specialist members examine the propriety of initial determination of claims as ineligible, have examined 656 cases since it started working September, 2006. The council is running on the track as expected, as accuracy of

determination has been raised in respect of ineligibility for illness prior to the policy inception date as well as failure to provide proper health condition statement.

- 1-3-3 The Claims Handling Examination Department (“CHED”), which monitors the propriety of claims payment, has checked 6,839 cases in the monthly examination as well as conducted an on-site examination at 75 service centers. The monthly examination checks extracted paid cases in which a certain eligible claim related thereto may be left unpaid. For the on-site examination, the CHED sends its staff to each of about 250 centers across the nation to monitor the propriety of claims payment. The CHED thus secures properness in the routine operations.
- 1-3-4 The Medical Support Office solely and exclusively determines illness prior to the policy inception date on third-sector claims before payment. It ensures proper determinations with cooperation from the resident advisory doctors, and has made 574 pre-payment determinations so far.

1-4 Application of customers’ comments to operation improvement

The Council on Promotion of Customers' Viewpoint met for the third time March 6, 2007. Following analysis of complaints on claims payment made at the first and second meetings, the council analyzed complaints on solicitation. The council raised the operational solutions to those points which were screened out by the trouble-shooting in a way of following through the complaints in the steps of renewal notice, product explanation, explanation of material facts, contract conclusion and declaration, policy maintenance and administration along the course of insurance sales activity.

2. New Challenge 10, the new medium-term management plan

2-1 Basic strategy of NC 10

NC 10, a medium-term management plan, was newly formulated for the coming four years beginning from fiscal 2007, and specific actions have been taken thereunder. NC 10 places top priority to quality improvement in its basic strategy and aims to transform customers’ trust so earned into driving force of corporate growth. To this end, the Company will keep spinning a spiral of “quality, trust and growth,” and thereby aims to be “a world’s top-level insurance and financial group seeking sustainable development with corporate quality as the main source of competitiveness.”

2-2 Quality improvement measures

Upon implementing NC 10, the Company’s group has set out “Quality Improvement Activity,” involving all employees and agents, for the purpose to ensure that routine work should follow “the basic cycle of insurance.” It is a process chain of sales activity, composed of “quotation and explanation of product,” “explanation of material facts and confirmation of intention,” “contract conclusion and declaration,” “policy maintenance and administration” and “renewal notice and follow-up.” The agents and the Company will, in a body in this activity, seek for quality improvements originating from customers’ viewpoint, and aim to have embedded “the basic cycle of insurance” by the end of fiscal 2008 at all agents of the Company.

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Appendix 1

Follow-up Results of Failure to Pay Claims for Expenses under Extra Riders and Inappropriate Non-payments for Third-sector Claims

1. Failure to Pay Claims for Extraordinary and Other Incidental Expenses

An investigation was conducted on cases of claims paid during the period from April 2002 to June 2005 with respect to failure to pay for extraordinary and other incidental expenses. As a result, follow-up procedures were completed in 50,767 cases or 98.6 percent out of 51,470 cases that had turned out as left unpaid.

2. Inappropriate Non-payments for Third-sector Claims such as Whole-life Medical Insurance

An investigation was conducted to review the propriety of determination on cases once determined as denial during the period from July 2001 to June 2006. As a result, follow-up procedures were completed in 1,136 cases or 99.6 percent out of 1,140 cases that had been confirmed as inappropriate non-payments.