

May 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, Chief Executive Officer, Toshiaki Egashira) today submitted the tenth 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.

The Company continues its efforts to embed corporate quality improvement in the routine operational approaches as first priority. In addition to carrying out the specific remedies as set in the BIP, the Company follows the BIP in improving and strengthening the systems of management and claims payment administration under the new medium-term management plan, New Challenge 10 embarked April 2007.

1. Corporate quality improvement

The Company strives, above all things, to embed orientation to quality improvements originating from customers’ viewpoint. The new group vision, “New Challenge 10,” was launched with the corporate quality enhancement campaign, which is now in action, aiming to ensure sales practices according to the “basic cycle of insurance.” Along with it, the “New Challenge 10 Meeting” is going on nationwide with a top executive’s participation, including the president, where he directly addresses the employees and agents present to the new vision for its dissemination among them. They have visited 13 sites 15 times in total so far, and are scheduled to finish visiting all the 20 bloc divisions by early June.

2. Further strengthening of the claims payment administration system

2-1. The claims handling division has increased its workforce by 415 persons in the aggregate (235 generalists and 180 clericals) as of April 1, 2007, in accordance with the resolution made August 2006. In addition, it was resolved to increase eight persons, comprised of 4 generalists and 4 clericals, effective May 1 and June 1. As a result, generalists and clericals will total 239 and 184 persons, respectively, by June 1, 2007. The employees of these reinforcements are supposed to take a group training session at the head office and master basics of the jobs before their assignments to local service centers.

Together with 9 more persons assigned effective April 1, staff dedicated solely to education at the claims handling divisions total 54.

2-2 It was determined that the Long-term Medical Center should include in its operations claims handling services of the V-Care long-term health insurance with a special rider of nursery care effective May1. The center solely handles all long-term medical claims in order to secure uniformity in the third-sector claims payment.

3. Claims complaints received by the Claims Handling Consulting Section

The Claims Handling Consulting Section has received 7,868 cases of inquiries, advice requests and complaints regarding claims payment since it started its operation September 1, 2006. At the section, 16 staff dedicated solely to the customer service work for quick and proper responses to incoming customers. Immediately after receiving a complaint, a staff member notifies the relevant service center of it via the CS / complaint response system, giving a concrete instruction of what to do with the complaining customer in helping him/her solve the problem. Even afterwards, the staff member follows the case, monitoring the service center's performance, until the problem is finally resolved.

4. Further strengthening of the legal compliance system

A training course has been given to about 580 employees, consisting of recruits of generalists and clericals as well as those promoted to sales generalist or general manager of a claims service center, under the multi-tiered program of legal compliance according to the recipients' position classifications.

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Appendix 2

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

1. Failures 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 of May 18, 2007, follow-up procedures were completed in 50,816 cases or 98.7% percent out of 51,465 cases that had turned out as left unpaid, as a result.

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 of May 18, 2007, 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, as a result.