

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) submitted the thirteenth report on the current status of implementation of the business improvement plan (“the BIP”). The Company had filed the BIP to the Financial Services Agency (“the FSA”) of Japan on July 21, 2006, and has taken specific measures thereunder since then.

This first report since the reporting schedule to FSA was changed to three-month frequency reconfirms our continued commitment to corporate quality enhancement as first priority within the organization. As set in the “New Challenge 10” mid-term management plan that was embarked in April, we are pursuing further improvement in the controlling systems of management, administration, etc., which were reconstructed and reinforced under the BIP, for proper solicitation and explanation to customers.

1. Improvement and strengthening of governance

1-1. Routine operations and BIP status reviewed by the Audit Committee

The Audit Committee has met 13 times since it was established as a committee within the Board of Directors on September 1, 2006. The committee monitors progress in the specific business improvement measures and examines the approaches taken in the corporate quality improvement in response to the reports presented by various departments. Its opinions on and findings in the reports are to be reflected on the operation system enhancement.

1-2. Strengthening communication between management and ‘front-line’ employees

Following the last year’s campaign, this year’s *Keiei Meeting* (or Meet-the-Management) started October 10. Last year, the chairman, the CEO and senior executives visit all the branches and Head Office Departments in Japan to exchange opinions on operational issues and solutions thereto with the front-line employees there. Suggestions gleaned therefrom will be reviewed to be taken up in the specific measures.

1-3. Monitor on operational systems by Corporate Quality Control Department

The Corporate Quality Control Department, established September 1, 2006, monitors the suitability of business operations, develops necessary remedies by oneself or together with relevant departments, and supervises implementation of such remedies. This new department is also carrying out revising explanatory literature regarding insurance products for better understanding of individual policyholders based on

customer survey, complaints received and advices from external professionals, including consumer lifestyle organization.

2. Improvement and strengthening of claims payment administration system, etc.

2-1. Dramatic review and improvement of claims payment administration system

(a) Strengthening of claims department capacity

In accordance with the resolution to reinforce the claims handling division adopted by the Management Committee in August 2006, 429 persons in total, consisting of 245 general staff and 184 clerks, were deployed to the division by October 1, 2007. The personnel appointed thereto received pre-assignment training at the head office as part of educational enhancement.

(b) Building claim inquiry system for accident desk staff

A new computer system for helping accident desk staff handle claim inquiries, which has been developed since October 2006, is going to work October 2007. This online system enables a help desk operator to register an accident immediately based on the policyholder reporting on the phone and to simultaneously answer all the eligible claims by inquiry from the terminal. In addition, the system prevents a certain eligible claim from non-payment due to input neglected at a service center.

(c) Examination for determination suitability by Claims Payment Examination Council

The Claims Payment Examination Council, consisting of third parties such as outside attorneys, consumer representatives and medical experts, commenced its work on October 1, 2006, and examined 816 cases in the Third-Sector Claims Examination Sub-committee and 269 cases in the General Claims Examination Sub-committee, totaling 1,085 cases, by the end of September, 2007. Data and competent knowledge accumulated through monthly examination at the council will be shared for continued effort to appropriately handle claims across the organization.

2-2. Dramatic review and improvement of product development system

(a) Review on product development system

After the Product Division was established on October 1, 2006 to aim a smoother and firmer cross-product-line cooperation in product improvement and control, a systematic process was introduced for products to be reviewed internal and externally and to pick up useful opinions and tips therefrom, working in a cycle of “product development,” “underwriting,” “sales / solicitation,” and “post-sale monitoring.” Actually, the Corporate Quality Control Department has succeeded in improving certain insurance policies for individuals by bringing into effect its analysis on the complaints received from customers and the suggestions made by agents and employees with regard to the products.

(b) Re-checking movement embarked

The “*Go-keiyaku Naiyo Shikkari Kakunin*” campaign, which has been implemented originally in the fire policy line since April in order to ensure appropriate underwriting by re-checking, has thereafter been extended one by one to other lines, and is now carried out in all the lines in personal related products. The “*Go-keiyaku Naiyo Shikkari Kakunin*” navigation service, available at our website, is one of the steps of providing tools for individual customers and agents to understand better the aim of the campaign and easily

follow the procedures in our continuous approach in order to ensure appropriate explanations to customers,.

3. Improvement and strengthening of policyholder protection and policyholder benefits

3-1. Strengthening of compliance education to employees and agents

The second Compliance Enhancement Month was conducted from July to August, following the one from January to February this year. Gathering the employees and agents, a training session of the campaign not only called them for reconfirming applicant's intention based on the rule advocated in the Go-keiyaku Naiyo Shikkari Kakunin movement but also emphasized practices based on fundamental knowledge of recognition and appraisal of structural grade of insured buildings in the fire policy line. The Company will continue its effort to press the basic rules of solicitation cycle on and remind the basic knowledge of the fire policy line of the employees and agents.

3-2. Dramatic review and improvement of complaints response and handling system

(by Council on Promotion of Customers' Viewpoint)

The Council on Promotion of Customers' Viewpoint has held six meetings by September, inclusive of the inauguration in October 2006. The council analyzed the complaints gathered by the Customer Service Department regarding claims handling, solicitation, policy maintenance and security and those received by the call center, and compiled opinions of the members for operational improvements to a recommendation to the Board of Directors.

4. Improvement and Strengthening of Legal Compliance System

4-1. Review on determination suitability of misconduct incident

The Misconduct Incident Examination Council, consisting of attorneys, has met 42 times from October 2006 through September 2007 in order to examine the pre-determined cases brought to it for suitability. The council examines such cases as to completeness of the investigation made and suitability of the pre-determination by the Compliance Department. If the council finds more discussion necessary for a case, it asks two or more lawyers individually for their opinions on the case, and makes a decision based on them as whether a further investigation is required or whether the pre-determination is appropriate.

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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 7th, 2006 and automobile and other non-third-sector claims on October 4th, 2006.

The Third-sector Claims Examination Sub-committee met for 29 times and the General Claims Examination Sub-committee for non-third sector claims 14 times from June through September. The Sub-committees collectively examined 157 cases and concluded that 82 of them were eligible and 76 ineligible.

Number of cases determined ineligible by the Claims Payment Examination Council

(July to September 2007)

Claims subject to examination	Reasons for ineligibility determination	Number of claims
Third-sector claims	(1) cases where the 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	25 claims
	(2) cases where the 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	none
	(3) other reasons (such as breach of duty to notify the insurer, policy invalidated due to fraud, policy canceled due to a material fact, certain illness and others specified as uncovered by policy, etc.)	none
Automobile, fire and personal accident claims	(1) cases where the death of the insured has no causal relationship with the accident or was caused by driving under influence of alcohol	44 claims
	(2) cases where an accident was intentionally caused by the relevant policyholder	6 claims
	(3) other reasons (such as breach of duty to notify the insurer and breach of duty to cooperate in investigation, etc.)	6 claims
	(total)	76 claims

Furthermore, all the third-sector claims determined ineligible due to prior-illness went through the preliminary medical examination by the Medical Support Office at the head office.

The Office preliminarily examined 284 claims from July through September, and 14 were determined eligible while 235 turned out ineligible due to prior-illness as a result.

Appendix 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 expense 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 October 18, 2007, the Company has completed the follow-up payments due in 50,981 cases (or 99.1%) out of 51,437 identified.

2. 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 1,136 cases (or 99.6%) out of 1,140 identified as of October 18, 2007.