

January 21, 2008

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 14th 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.

The reporting was changed to three-month frequency from the previous report. The Company has fulfilled all the specific assignments and reconstructed the systems of the issue as prescribed in the BIP by January, 2008. We hereby reconfirm 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 2007, 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 met 15 times by December 2007 since it had been 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 continued operation system enhancement.

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

As had done in the previous year, the *Keiei Meeting* (or Meet-the-Management) campaign started October 10, 2007, in which the chairman, the CEO and senior executives should 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. For the current fiscal year, top managers explained the significance of the New Challenge 10 and the approaches to corporate quality improvement to the front-line employees at 71 meetings of their respective sites in total they visited during the three months from October to December. There were also made fruitful discussions over the contract re-checking scheme in underwriting (*Go-keiyaku Naiyou Shikkari Kakunin* movement) and the efforts to secure fair, uniform and speedy claims handling

(*Son-sa God Job* movement). Opinions gleaned therefrom are reviewed to be taken up in the specific measures of corporate quality improvement. They are, for example, forwarded to the relevant Head Office Departments and screened there to be taken up for check-up of the specific measures, and those matters which have been frequently pointed out at various meetings are to be posted on the in-house website.

1-3. Strengthening communication with agents

A survey regarding a new fire policy to be developed for individuals and medium- and small-sized companies was conducted to the Company's agents over the Agent MS1, the Company's Internet service of communication with the agents, during the period from November 15 to 30, 2007, and about 600 agents sent their views in return. These views collected from the agents facing customers every day are used in developing the new product for the purpose of promoting "easiness to understand and quality improvement." Besides, the top management of the Company met managers of MSA, the organization of agents recognized as high contributors by the Company, and exchanged opinions at the All Japan MSA Managers' Meeting held on January 11, 2008. The assembly resolved to adopt the fourth quarter policy that the members should fully fulfill the *Go-keiyaku Naiyou Shikkari Kakunin* movement and thereby lead other agents in the quality improvement efforts promoted by the Company. Also, they confirmed their continued commitment to the quality improvement efforts along the Company's line.

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

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

(a) 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 September 1, 2006, and examined 957 cases in the Third-sector Claims Examination Sub-committee and 335 cases in the General Claims Examination Sub-committee, totaling 1,292 cases, by December, 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.

(b) Determination suitability regarding prior-illness secured by Medical Support Office

The Medical Support Office was established with nine dedicated staff on October 1, 2006, and re-examines all the disease claims that have been pre-determined ineligible due to illness prior to the policy inception date by the local service centers in order to secure suitability of final determination as prior-illness as to the said claims. 1,429 cases were examined prior to final determination in total by the end of December 2007.

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

The Company resumed sales of whole-life medical insurance with policies effective December 2007 and thereafter, and had reconstructed the underwriting and solicitation systems and revised the products as necessary to get ready for that. Specifically, the Whole-life Medical Handling Agency Qualification was initiated and the education program for agents was reinforced. In addition, the form of health condition statement was totally revised, and the solicitation manual was reviewed to be yet easier to be understood so that applicants should be aware that they should duly present the health condition.

3. Improvement and strengthening of policyholder protection and policyholder benefits

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

The third series of Compliance Enhancement Month is going on from January to February 2008, following the Jan/ Feb-2007 and Jul/Aug-2007 campaigns. Gathering agents, the training session focuses on the basic matters regarding the solicitation rules and the major errors and inadequate handling detected in the re-checking movement. Prior to the agent training, the employee training course had reviewed those matters to be handled in the agent training session and ensured that the attending employees should master them. Moreover strict information control was called for as well as complaint registration without exception and prevention from recurrence of complaints such as once registered.

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 held 7 meetings by December 2007, 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 the analysis with 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 55 times during the period from October 2006 to December 2007 in order to examine the pre-determined cases brought to it for suitability. The Council examines cases presented by the Compliance Department as to ampleness of the investigation and suitability of the pre-determination by the said department, takes the individual opinions from two or more lawyers on the case into account, and makes a decision as to 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 25 times and the General Claims Examination Sub-committee for non-third sector claims 15 times during the period from October to December 2007. The Sub-committees collectively examined 175 cases and concluded that 69 of them were eligible and 96 ineligible.

Number of cases determined ineligible by the Claims Payment Examination Council

(October to December 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	36 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	4 claims
	(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.)	3 claims
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	31 claims
	(2) cases where an accident was intentionally caused by the relevant policyholder	9 claims
	(3) other reasons (such as breach of duty to notify the insurer and breach of duty to cooperate in investigation, etc.)	13 claims
	(total)	96 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 294 claims during the period from October to December 2007, and 26 were determined eligible while 255 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 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 January 20, 2008, the Company has completed the follow-up payments due in all the cases of the 51,410 identified, except few cases yet remaining due because of certain reasons on the side of the relevant policyholders.

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 all the cases of 1,140 identified as of January 20, 2008, except few cases yet remaining due because of certain reasons on the side of the relevant policyholders.