August 1, 2008

Submission of Business Improvement Plan

The Dai-ichi Mutual Life Insurance Company (the "Company"; President: Katsutoshi Saito) today submitted its business improvement plan to the Financial Services Agency (FSA) in accordance with the administrative order (Business Improvement Order) of July 3, 2008. We deeply apologize to our customers as well as our stakeholders for the inconvenience and concern regarding our payment operations, the core of our life insurance business.

On receiving the order, the Company established the "Headquarters for Business Improvement Promotion" (the "Headquarters") on July 3, 2008, consisting of all operating officers of the Company, in order to proceed with the business improvement plan on a company-wide basis. Hereafter, the Headquarters will proactively promote the plan, monitor its effectiveness and readjust it as necessary by promoting the concept of the "PDCA" (plan-do-check-action) cycle from our customers' perspective for continuous improvement of the Company's business.

Taking the administrative order with utmost seriousness, all of the directors, officers and employees of the Company share the recognition that the role of an insurance company is fulfilled when a claim payment is completed. We will strive to implement the business improvement plan to prevent a recurrence of insufficient payment issues, and we will work to restore the public's trust.

Summary of the business improvement plan is as follows:

I . Summary of the Business Improvement Plan

1. Improvement and Reinforcement of Governance Structure

i) Establishment of the "Headquarters for Business Improvement Promotion" and Reinforcement of internal system to monitor the effectiveness of the plan (July 2008)

- The Company established the "Headquarters for Business Improvement

Promotion" on July 3, 2008 in order to proceed with the business improvement plan on a company-wide basis.

- The Headquarters consists of all operating officers of the Company, in order to promote proactive and unified management participation, and is responsible for promoting the business improvement plan.
- In an effort to achieve continuous improvement, the Headquarters promotes the concept of the PDCA cycle, monitors the status and effectiveness of the Company's business improvement plan and readjusts the plan as necessary, taking into consideration reports from the Company's claims examination, internal auditing, and other relevant departments.
- The Headquarters intends to utilize a Deliberation Committee for Claims Payment as a consultative body in order to monitor and assess the effectiveness of the plan from a third-party perspective.
- The Company plans to disclose its progress on the plan periodically.

ii) Clarification under medium-term management plan (July 2008)

- The Company prioritized implementation of the "Declaration of Quality Assurance"(1) and productivity improvement associated with the implementation of its medium-term management plan for fiscal year 2008 to 2010 (to be disclosed in mid-August 2008). Specifically, the Company commits itself to completing the business improvement plan, enhancing effectiveness of the plan, and promoting the PDCA cycle.
- In its medium-term management plan, the Company pledged such items as reinforcement of the processes relating to receipt of claims, development of claims examination information systems, and maintenance of the effectiveness of the plan.

(1) In September 2006, the Company formulated and announced the "Declaration of Quality Assurance", the embodiment of the management concept of "Policyholder First", which has been the philosophy of the Company since its foundation.

iii) Further specification, schematization and familiarization of the "Declaration of Quality Assurance" (September 2006)

- To realize the "Declaration of Quality Assurance", the Company will specify and schematize each article of the declaration to achieve "the required quality" (the ideal model that customers expect). Also, the Company will strive to familiarize its directors, officers and employees with the specified and schematized declaration.

2. Improvement and Reinforcement of Internal Audit Structure

i) Change in officer structure (September 2008)

- To strengthen the Company's internal controls and clarify monitoring functions,

officers responsible for internal auditing departments of the Company will not take charge of audited departments but will instead take charge of its internal control departments.

ii) Reinforcement of internal audits by Internal Control and Auditing Department

- The Company will set up a new division to monitor claims payment systems and allocate employees with claims examining experience to this division in September 2008 to strengthen the effectiveness of the business improvement plan.
- In addition to periodic internal audits already conducted, the Company will implement organization-wide theme-specific internal audits of product development management from the second half of fiscal year 2008.
- In order to check the effectiveness of the audits of its claims payment departments, from August 2008 the Company will reinforce its system for monitoring the Underwriting Management Center responsible for claims re-examination.

iii) Reinforcement of monitoring functions assigned to Underwriting Management Center (October 2008)

- The Underwriting Management Center, whose main role has been to investigate the Company's past insufficient payments, will additionally take charge of self-inspection and will re-examine daily claims payments.
- The Company has conducted and utilized customer surveys since fiscal year 2007 to improve its claims payment operations. The result of the surveys will be reported to the Deliberation Committee for Claims Payment to reinforce its checks against the claims payment departments and to improve the operation of the Company from the customers' perspective.

3. Readjustment and Improvement of Preventive Measures

1) Communication with policyholders

i) More provision of policy-specific information to each policyholder

- In January 2009, the Company intends to revise the "Pamphlet on Payment of Claims & Benefits" that it sends to each policyholder, in order to reflect the results of its customer surveys.
- The Company started providing a customized list of payment conditions for each customer in May 2008.
- In August 2008, the Company will add to the "Total Life Plan Report" annually sent to each policyholder additional items such as a customized list of events being covered and payment conditions for each customer.

ii) Information provision using the Company's website (August 2008)

- In order to provide necessary information to customers when they need it, the

Company will supply a web-based “Total Life Plan Report” to each policyholder.

iii) Encouragement to submit a claim 120 days after hospital discharge (October 2007)

- The Company sends claimants for hospitalization payments a guide 120 days after their hospital discharge to confirm whether they need to submit a claim for their hospital visit. The Company will continue to improve, among others, language in its documentation encouraging claims from customers’ perspective.

iv) Additional information on “Description of Claims Payments” (currently in practice)

- The “Description of Claims Payments” includes language encouraging claimants to confirm that they are not overlooking any potential claims.
- The Company will improve the quality of information sent to policyholders to encourage them to make claims, taking into consideration consumers’ opinions.

2) Claims Payments

i) Reinforcement of accuracy of claims receipts (currently in practice)

- To properly understand information included in customers’ claims and to encourage them not to overlook any potential claims, the Company is revising its internal forms to process claims received and has sent all its unit offices outlines to check the forms. The Company will continue to improve its operation accuracy on claims receipts by improving its internal forms as well as the inspection systems in its branch offices.
- To encourage claimants to make sure they have made all potential claims, the Company provides them with a claims check sheet. Likewise, the Company will continue to improve the clarity and legibility of its claims paperwork.

ii) Reinforcement of process of claims receipt (first half of FY 2009)

- Instead of handwriting the form to receive claims, the Company’s salespersons will type all information obtained from claimants into their mobile PCs. The Company will then transfer the information directly to its information system in order to eliminate human error associated with handwriting the forms.
- A claims confirmation sheet and other claims documents will be distributed to claimants in order for them to review their claims.

iii) Development of claims examining information system (from September 2008)

- When inputting information on medical certificates into the claims examining information system, the Company will use the entry/verify method, an effective scheme to detect typing errors, to eliminate inputting errors.
- The Company will convert information on medical certificates to electronic data as soon as it receives the certificates in order to utilize the data in claims examination.

iv) Further development of claims examining information system (FY 2009)

- The Company will reduce operations requiring human skills, establish further division of labor in claims examinations and facilitate checks using computer systems.
- The Company will also develop its group insurance system to strengthen its function of claims examination.

v) A framework to monitor payments (May 2009)

- The Company will set up a framework that re-examines whether there is insufficient payment immediately after payments are made.

vi) Continuous encouragement for customers to make claims (October 2007)

- Even after payments are made, the Company will continue to re-examine medical certificate information stored in its "Payment Information Integration System" to seek further insufficient payments.

3) Product development management

i) Improvements to the Company's product development management (currently in practice)

- People in charge of product development will give special emphasis to the review of benefit payment workflows, even during preliminary phases of development.
- The product development departments and the claims payment departments review payment workflows with a checklist even before a decision has been made to develop a particular product.
- The Company will establish an internal regulation that requires the termination of product development if there is difficulty creating a clear benefit payment workflow for a particular product.
- The Company will reinforce its management of after-sales service.

ii) Easy-to-understand policy terms and conditions (June 2008)

- The Company revised the terms and conditions of new policies in June 2008 to make them easier understand. The Company will revise terms and conditions of renewal policies in October 2008.
- The Company will continue to improve the policy terms and conditions, taking into consideration the requests of consumers and the claims payment departments for further improvement.

iii) Readjustment of product line

- The Company will periodically revise and terminate products as appropriate in

order to prevent insufficient payments and insufficient guidance.

- The Company suspended its sales of more than 30 products in April 2008.

4) Preventive measures against insufficient payments and insufficient guidance

Please refer to the attached for information on preventive measures, including those already implemented.

Ⅱ. Internal Disciplinary Actions

Taking seriously the situation that led to the business improvement order, the Company clarified the responsibility of its directors, officers and employees for this issue and took strict internal disciplinary actions.

Overview of Preventive Measures

From the start of the contract to the claims receipt

Reinforcement of product development management and easy-to-understand product line-up

- Improvement in basic policy and internal regulations related to product development and claims payments

- Reinforcement of the linkage between departments responsible for product development and claims payments
  (ex.) -examine the payment workflow even during the preliminary phases of developing new products

- Readjustment of the product line from the viewpoint of whether insufficient payments may occur
  (ex.) –suspension of sales of “Hospital Visit Rider” (Apr.2007)
  -development of hospitalization rider which is easier to understand for customers

- Revision of policy terms & conditions to make them easier to understand

Reinforcement of providing policyholders with information to make claims

- Improvement of the “Total Life Plan Report” sent annually to each policyholder (Aug.2008, planned)

- Provision of a customized list of payment conditions for each customer (May 2008)

- Provision to all policyholders of **“**Pamphlet on Payment of Claims & Benefits**”**, which explains cases where payments will be made and the procedures to make claims

- Reinforcement of website disclosure
  (ex.) -renewal of the homepage to improve usability (Jul.2008)
  -supply of digital books on the website (Sep.2007)

- Reinforcement of providing information to policyholders
  (ex.) –Addition of information related to claims payments in product brochures and other documents sent to policyholders

Improvement in circumstances for policyholders to make a claim

- Compensation for the cost of medical certificates in cases where payments were inapplicable

Reinforcement of structure to understand the reason for the claim correctly

- Open a call center for salespersons’ inquiries on claims payments and claims procedures (Jan.2008)

Reinforcement of educational structure for correct payments

- Establishment of a group that has comprehensive responsibility for the education and training for employees and salespersons (Apr.2007)

- Establishment of the “Administration and Underwriting Academy” for employees (Nov.2007)

- Improvement in education for salespersons
  (ex.) -regular training regarding administrative procedures

- Improvement in compliance training

Attachment

Overview of Preventive Measures

"Correct understanding of the reason for the claim", "Appropriate guidance" and "Correct and prompt payment"

When payments are made → After the payment

1. Receipt of the Claim

Correct understanding of the reason for the claim

- Revision of the administrative procedures for receiving claims
  (ex.) -clarification of the questions that customers should be asked
  -revision of the internal form used when intention of the claim is recognized (Apr.2008)

2. Provision of the Claim Form

Appropriate guidance

- Improvement in the operation
  (ex.) -review of the rules for checking the claim form

Prevention of insufficient guidance

- Provision of a check sheet for claimants to make all their potential claims
- Distribution of a document which guides policyholders to check whether they are eligible for claiming hospital visit benefits (Apr.2007)

3. Claims Examination

Correct and prompt claims examination

- Improvement in administrative standards
  (ex.) -introduction of quality management indicator to enhance administrative quality (Apr.2007)
- Introduction of "entry-verify method", an effective scheme to detect typing errors, to eliminate input errors (Sep 2008, planned)
- Use of stored data for claims examination (Sep.2008, planned)

After the payment

Correct and prompt payment

- Set-up of a system to re-examine whether there is insufficient payment immediately after the payment are made (May 2009, planned)

Appropriate guidance

- Use of "Payment Information Integration System" in daily operations (Oct.2007)
- Addition of information on "Description of Claims Payment" (Apr.2008)
- Guidance to claimants for hospitalization benefit 120 days after their hospital discharge to confirm whether they need to make a claim for their hospital visit (Oct.2007)

Reinforcement of the system from claims receipt to guidance

- Clarification of administrative rules related to claims receipt and guidance
  (ex.) -provision of a guideline for checking internal forms that salespersons fill in when they receive claims (Jul.2008)
- Enhancement of the process of accepting claims (1st half of FY2009, planned)
  (ex.) -claims receipt by using mobile PCs, instead of handwriting the form
  -provision of a feedback sheet to claimants

Appropriate guidance

- Revision of the form of medical certificate (Feb.2007)
- Enhancement of claims examination information system (FY 2009, planned)