

April 13, 2007

Status of additional payments of claims and benefits, etc.

The Company (President: Kunie Okamoto) today submitted a "Status of claim payments report" as ordered by the Financial Services Agency on February 1, 2007. The following pages contain a summary of that report.

As a result of inspection, the Company is proceeding with successive payments to customers for whom additional payments of claims and benefits have been found to be necessary. Also, in cases where additional payment is possible by receiving new requests from customers, the Company will provide guidance for eligible customers in due course. The Company asks that new requests by customers be made after thorough confirmation.

The Company deeply regrets and apologizes that this situation has come about and that many customers have been caused concern and inconvenience. The Company is working to restore customer confidence by swiftly proceeding with procedures for additional payments and taking thorough measures to prevent recurrence.

The Company is continuing inspections and by June 30, 2007 will confirm the customers who will be given guidance for additional payments. Also, the Company plans to carry out additional payments of claims and benefits in sequential order, completing them by the end of September 2007. Upcoming progress reports will be announced.

An exclusive call center, described below, will handle inquiries on policy content and payments.

【 Call center exclusively for customers starting April 14 (Saturday) 】

0 1 2 0 - 9 4 5 - 5 6 1 (toll free)

{ [operating hours] Monday-Friday 9 : 0 0 ~ 1 7 : 0 0 }

1. Summary of inspection results

(1) Inspection targets

- The Company inspected all policies for which claims or benefits were paid during the period from April 1 2001 to March 31, 2006.

【 Table 1: Breakdown of policies subject to inspection 】

Total	Claims	Benefits	Group insurance
3,690,451	314,567	3,211,531	164,353

(2) Inspection content and results

① Cases where payment of claims or benefits was insufficient

- The Company conducted a voluntary inspection using its Policy Inspection Center (organization of about 1,200 staff at peak) after April 2006 to confirm the appropriateness of underwriting, focusing on the information from medical certificates submitted by customers.
- As a result, shown in 【 Table 2 】, the Company found cases where claim and benefit payments that should have been made were not made. Regarding those policies, the Company is currently providing guidance in sequential order and carrying out additional payments of claims and benefits.
- Also, specific examples of cases of insufficient payments are shown on the Attachment.

【 Table 2: Number and amount of claims and benefits where payment was insufficient 】

	Total	Claims	Benefits	Group insurance
Number [A] (Paid)	14,190 (2,495)	4 (1)	14,044 (2,400)	142 (94)
Amount [B] (units: ¥10,000) (Paid)	128,753 (25,580)	735 (126)	122,074 (20,971)	5,944 (4,483)
Ave. payment amount per case [B/A]	¥90,735	¥1,838,814	¥86,922	¥418,600

②Cases where guidance should be given for requests of claims and benefits

- The Company, having received an order to report, is implementing special inspections using approximately 4,600 staff in branches throughout Japan and in organizations newly established within the Policy General Affairs Dept., including the “Special Inspection Promotion Team,” “Head Office Inspection Center,” “Marunouchi Inspection Center,” and the “Urayasu Inspection Center.”
- In the special inspection, in addition to the already paid claims and benefits, from the perspective of determining the necessity of providing guidance to customers for requesting further payments, the Company is implementing an inspection that again looks at the content of medical certificates in light of the attachment of riders. As a result of the afore-mentioned voluntary inspection and this special inspection, the Company found cases where guidance should be provided to customers for requesting payment of claims and benefits.
- Regarding such policies, the Company is providing guidance to customers in order of precedence. Regarding claims and benefits that have been newly requested, the Company will confirm the necessary payment amount following an examination. Please understand that the Company will carry out payment as soon as confirmation is complete.
- Also, because this special inspection is currently underway, the Company expects that the number of cases where customers will request claims and benefits will further increase, and the announcements concerning the process will be made.

【Table 3: Number and amount of confirmed cases where payment was made in addition to initially paid claims and benefits】

	Total	Claims	Benefits	Group insurance
Number [C] (Paid)	1,260 (176)	1,254 (172)	6 (4)	-
Dread disease claims (Paid)	1,253 (171)	1,253 (171)	-	
Amount [D] (Paid) (units:¥10,000)	¥476,636 (¥71,675)	¥474,011 (¥69,850)	¥2,625 (¥1,825)	-
Dread disease claims (Paid)(units:¥10,000)	¥472,011 (¥67,850)	¥472,011 (¥67,850)	-	
Ave. amount per case [D/C]	¥3,782,825	¥3,779,992	¥4,375,000	-
Dread disease claims	¥3,767,047	¥3,767,047	-	

③ Cases where payment other than claims and benefits was insufficient

- The Company, through its afore-mentioned voluntary inspection, completed a check of the appropriateness of reference dates for interest arrears by March 31, 2007 with regard to all claims and benefits paid from April 1, 2001 to March 31, 2006.
- Also, the Company carried out a broad inspection of the administrative process for all payments after August 2006. Inspection was completed by March 31, 2007 for a total of approximately 43,000 items, covering “status of administrative rule development,” “consistency of administrative rules and policy provisions,” “appropriateness of administrative handling,” “appropriateness of system,” and “frequency of complaints and administrative errors.”
- As a result of the inspection, indicated in 【Table 4】, the Company found cases where payments, other than claims and benefits, were insufficient. The Company is providing guidance to the policyholders concerned and making necessary payments for the amount lacking.

【Table 4: Number and amount of cases where payment other than claims and benefits was insufficient】

	Total	Interest arrears	Other(*)
Number [E] (Paid)	41,620 (8,215)	40,936 (8,082)	684 (133)
Amount [F] (Paid) (units:¥10,000)	8,265 (1,961)	7,664 (1,650)	600 (310)
Ave. amount paid per case [F/E]	¥1,985	¥1,872	¥8,776

(*)Other: Dividend calculation error accompanying cancellation due to policyholder’s notification breach in 550 cases totaling ¥2,880,000, interest rate discrepancy for asset formation annuity insurance in 116 cases totaling ¥3,000,000, expense deduction errors for variable insurance in 16 cases totaling ¥70,000, prepaid premium discrepancy at time of claim payment for pension insurance serious disability rider in 2 cases totaling ¥50,000.

[Guidance for procedure of reinstatement of lapsed policy or cancellation]

- The Company is providing guidance for procedure of reinstatement or cancellation regarding approximately 750,000 policies that were lapsed as of February 1, 2007, from among policies that lapsed between April 2001 to March 31, 2006. As a result, by April 9, 2007, in approximately 56,000 cases, there were cancellation requests totaling approximately ¥1.4 billion, and the Company has already paid approximately ¥1.176 billion for 46,470 cases. Also, the Company expects that the number of cancellations and amount of surrender benefits will further increase.

2. Recurrence prevention strategy

(1) Reconstruction of administrative system from the perspective of policyholders

① Introduction of rules for guidance to policyholders when receiving payment requests [September 2007]

- In regard to receiving requests for payment of claims and benefits, and when providing advice, the Company will newly establish rules for confirming all the policies and riders held by the policyholder for which payment can be made. According to the new rules, the Company will introduce a “self check sheet” for policyholders to carry out self confirmation.

② Establishment of the “Claims-related Services Department” (tentative name) [July 1, 2007]

- In order to pay claims and benefits in an accurate, fast, and easy-to-understand manner, the Company will establish a Claims-related Services Dept. to plan and promote customer response measures.
- When assessing claim and benefit payments, and at other times when further payment is possible based on the request content and policy details, the Company will provide guidance to policyholders.
- As a continuation of the recent inspection, the Company is investigating the content of assessments of claims and benefits paid after April 1, 2006.

③ Revision of medical certificate form [December 2007]

- In most cases where claims and benefits payments are insufficient because assessors overlook or misread something on the medical certificate or surgical information is misapplied. The Company will create a new form that is easy for doctors to fill out and that is practical for payment assessment. (E.g., improve space for entering surgical information; add a space for remarks, etc.)

(2) Improvement of procedure for providing explanation to policyholders

① Improvement of provision of information for policyholders

- Regarding the business information pamphlet, “NISSAY 2007,” delivered to all policyholders, “Policy content announcements,” delivered once a year to all policyholders, and “Payment details” for claims and benefits, etc., the Company will make notifications to raise awareness so that claims and benefits are requested in full.

② Improvement of training and revision of sales representative system

- The Company will improve training of its employees to thoroughly promote its value system based on the belief that the duty of sales representatives is “to strive to serve customers by taking responsibility from the time of entry until payment of benefits.” In both the head office and on the sales front, the Company will improve training for after-service of policies.
- Regarding sales representative evaluations, the Company has implemented system revisions so that evaluation standards are based on “fundamental duties” such as contract completion process and

after-sales service.

③Improvement of explanations and visits to policyholders regarding payments

- In order to promote deeper understanding among customers of requests for payment of claims and benefits, the Company will improve visitation activities and explanations by approximately 50,000 sales representatives nationwide.
- When visiting customers, sales representatives will provide explanations and carry “Receiving claim payments” pamphlets that explain procedures for requesting claims and benefits, and “Consistent protection. Superior services.” pamphlets that explain payment reasons/amounts and payment request procedures based on each customer’s policy content.

(3)Development of infrastructure that supports customer service

①Promotion of large-scale system development (¥50 billion additional investment)

- In order to further ensure there is a framework where every eligible policyholder can request payments, the Company will increase its system investment to ¥150 billion, ¥50 billion more than the ¥100 billion assumed by the business improvement plan dated August 25, 2006.
- Specifically, based on broad inspection of the administrative process and the current special inspection results, alongside development of the “Next Generation Underwriting System” and “New Integrated System” aimed at 2011, the Company will strengthen functions for providing guidance to policyholders for requesting payments and for the administrative process.

②Promotion of computerization of medical certificate forms

- In light of the fact that the current special inspection has found that numerous problems clearly stem from medical certificate forms, the Company considers that promoting computerization and standardization of medical certificate forms with the help of medical institutions, to improve the forms that are currently filled out by hand, will contribute to the infrastructure development of the entire insurance industry.
- Specifically, the Company aims to promote the spread of software that creates computerized medical certificate forms, in order to reduce doctors’ burden of preparing the forms along with preventing mistakes by insurance companies in reading the forms, thereby realizing faster smoother payments. Nissay Information Technology has developed such software, and the Company is promoting further spread of the software beyond the 36 companies that already use its medical certificate digitized format for life insurance, nonlife insurance, mutual aid insurance, and postal life insurance.

Status of additional payments of claims and benefits

(Cases where payment of claims and benefits was insufficient)

(as of April 13, 2007)

	Insufficient payment		Completion of additional payment		Specific examples		
	Number (#cases)	Amount ¥1,000	Number (#cases)	Amount ¥1,000			
Claims	Death	1	1,260	1	1,260	Cancer was entered as the cause of death on the death certificate, but this was overlooked, and ordinary death claim was paid when a claim for death due to cancer should have been paid.	
	Accident	-	-	-	-	-	
	Serious disability	-	-	-	-	-	
	Specified illness (dread diseases)	3	7,000	-	-	-	Cancer was entered on the medical certificate, but this was overlooked, and specified illness claim was not paid.
	Other	1	95	-	-	-	When dread disease claim was paid, insurance premium waiver rider was overlooked and was not applied.
Claim total	5	8,355	1	1,260	-		
Benefits	Hospitalization	3,193	268,092	272	28,896	Hospitalization information was entered on the medical certificate in a place other than "hospitalization term column" and was overlooked, so hospitalization benefit was not paid. The date of hospital release on the medical certificate was read incorrectly, and hospitalization benefit was not paid.	
	Surgery	9,220	732,722	2,026	159,018	Surgery information was entered on the medical certificate in a place other than the "surgery column" and was overlooked, so surgical benefit was not paid. Regarding surgery with different payment according to symptoms, confirmation of symptom level was inadequate, so surgical benefit was not paid.	
	Disability	238	221,465	72	63,731	When receiving payment request, eligibility for specified physical disability status was overlooked.	
	Hospital visit	992	6,918	102	523	Hospital visit information entered on the medical certificate in the "Hospital visit column" was overlooked, and hospital visit benefit was not paid.	
	Other	542	49,985	22	2,377	Although bone fracture was entered on the medical certificate in the "injury details column," this was overlooked, and specified injury benefit was not paid.	
Benefit total	14,185	1,279,184	2,494	254,545	-		
Total	14,190	1,287,539	2,495	255,805	-		

(Cases where it was found during payment request guidance that additional payment should be made for claims and benefits)

	Insufficient payment		Completion of additional payment		Specific examples	
	Number (#cases)	Amount ¥1,000	Number (#cases)	Amount ¥1,000		
Claims	Serious disability	1	20,000	1	20,000	When request was received for dread disease claim payment, on the medical certificate submitted, there was an entry eligible for serious disability status, but this was overlooked.
	Specified illness (Dread diseases)	1,253	4,720,110	171	678,500	When a request was received for hospitalization benefit payment, cancer was listed on the medical certificate submitted, but this was overlooked.
	Claim total	1,254	4,740,110	172	85	-
Benefits	Disability	6	26,250	4	18,250	When a request was received for serious disability claim payment, it was overlooked that the same policy was also eligible for injury rider payment.
	Benefit total	6	26,250	4	18,250	-
Total	1,260	4,766,360	176	716,750	-	