

UNITED STATES BANKRUPTCY COURT
DISTRICT OF DELAWARE


PROOF OF CLAIM

Indicate Debtor against which you assert a claim by checking the appropriate box. (Check only one Debtor per claim form.)

- Conexant Systems, Inc. (Case No. 13-10367) Brooktree Broadband Holdings, Inc. (Case No. 13-10369)
 Conexant CF, LLC (Case No. 13-10368) Conexant, Inc. (Case No. 13-10370)
 Conexant Systems Worldwide, Inc. (Case No. 13-10371)

NOTE: Other than claims under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for Administrative Expenses arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503(a).

Name of Creditor (the person or other entity to whom the debtor owes money or property):

Name and address where notices should be sent:
 31951543000890
 BRUDER, JANET
 6313 MAROON MESA DR
 COLORADO SPGS, CO 80918-2658

RECEIVED
 MAY 09 2013
 BMC GROUP

If you have already filed a proof of claim with the Bankruptcy Court or BMC, you do not need to file again.

THIS SPACE IS FOR COURT USE ONLY

Creditor Telephone Number (719) 599-4635 email: fch.bruder@AEROFLEX.COM

Name and address where payment should be sent (if different from above):

Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number (if known):

Filed on: _____

Payment Telephone Number () email:

1. AMOUNT OF CLAIM AS OF DATE CASE FILED \$ SEE ATTACHED

If all or part of your claim is secured, complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2. BASIS FOR CLAIM: (See instruction #2) HEALTH INSURANCE, LONG-TERM DISABILITY, 401K, PENSION

3. LAST FOUR DIGITS OF ANY NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

4328

3a. Debtor may have scheduled account as:

(See instruction #3a)

3b. Uniform Claim Identifier (optional):

(See instruction #3b)

4. SECURED CLAIM: (See instruction #4)

Check the appropriate box if your claim is secured by a lien on property or a right of set off, attach required redacted documents, and provide the requested information.

Nature of property or right of setoff:

Describe:

Real Estate Motor Vehicle Other _____

Value of Property: \$ _____

Annual Interest Rate: % Fixed or Variable (when case was filed)

Amount of arrearage and other charges, as of time case filed, included in secured claim, if any: \$ _____

Basis for Perfection: _____

Amount of Secured Claim: \$ _____

Amount Unsecured: \$ _____

5. Amount of Claim Entitled to Administrative Expense status under 11 U.S.C. § 503(b)(9) or Priority under 11 U.S.C. § 507(a). If any part of the claim falls into one of the following categories, check the box specifying the administrative expense or priority and state the amount.

Amount entitled to priority: \$ _____

Amount entitled to administrative expense under 11 U.S.C. § 503(b)(9): \$ _____

You MUST specify the priority of the claim:

- Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).
 Up to \$2,600* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(7).
 Wages, salaries, or commissions (up to \$11,725*), earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4).

- Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
 Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5).
 Other - Specify applicable paragraph of 11 U.S.C. § 507(a) (_____).
 Value of goods received by the debtor within 20 days before the date of the bankruptcy filing - 11 U.S.C. § 503(b)(9).

* Amounts are subject to adjustment on 4/1/13 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

6. CREDITS: The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

Conexant Systems



00086

7. DOCUMENTS: Attached are redacted copies of documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and redacted copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. (See instruction #7, and definition of "redacted").

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

DATE-STAMPED COPY: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is actually received on or before 4:00 pm, prevailing Eastern Time on May 17, 2013 for Non-Governmental Claimants OR on or before August 27, 2013 for Governmental Units.

BY MAIL TO:
BMC Group, Inc.
Attn: Conexant Systems, Inc. Claims Processing
PO Box 3020
Chanhassen, MN 55317-3020

BY MESSENGER OR OVERNIGHT DELIVERY TO:
BMC Group, Inc.
Attn: Conexant Systems, Inc. Claims Processing
18675 Lake Drive East
Chanhassen, MN 55317

8. SIGNATURE: (See instruction #8)

Check the appropriate box.

- I am the creditor. I am the creditor's authorized agent. I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Janet E. Bruder
Title: _____
Company: Conexant Systems, Inc
Address and telephone number (if different from notice address above): _____

Janet E. Bruder 5/5/13
(Signature) (Date)

Telephone number: _____ email: _____

Attachment

It is hard to set a exact amount for a claim. Janet currently get her health insurance through Conexant. This includes dental and vision as well. She does not know how much it is going to increase in the future, but is sending a copy of benefits they pay for 2013. She is on the EPO family plan. She also gets long-term disability checks monthly and she is sending a copy of that as well. She currently has money in her 401K which is administered by Fidelity and she is vested in the pension which is administered by Rockwell Collins.

Appendix A: 2013 BENEFIT COSTS

Medical, Dental and Vision Plans

Plan	Coverage Level	Total Annual Cost	Total Monthly Cost	Company Paid Portion (Monthly)	Employee Paid Portion (Bi-Weekly)*
Anthem Blue Cross EPO	Employee	\$5,281.80	\$440.15	\$389.53	\$23.36
	Employee + Spouse	\$10,563.12	\$880.26	\$779.03	\$46.72
	Employee + Child(ren)	\$9,507.00	\$792.25	\$701.14	\$42.05
	Employee + Family	\$15,844.80	\$1,320.40	\$1,168.55	\$70.08
Anthem Blue Cross PPO	Employee	\$6,730.20	\$560.85	\$468.31	\$42.71
	Employee + Spouse	\$13,460.28	\$1,121.69	\$936.61	\$85.42
	Employee + Child(ren)	\$12,114.48	\$1,009.54	\$842.97	\$76.88
	Employee + Family	\$20,190.60	\$1,682.55	\$1,404.93	\$128.13

Delta Dental PPO	Employee	\$779.04	\$64.92	\$54.53	\$4.80
	Employee + Spouse	\$1,466.40	\$122.20	\$102.65	\$9.02
	Employee + Child(ren)	\$1,672.44	\$139.37	\$117.07	\$10.29
	Employee + Family	\$2,153.76	\$179.48	\$150.76	\$13.26

Vision Service Plan (VSP)	Employee	\$108.12	\$9.01	\$7.21	\$0.83
	Employee + Spouse	\$173.04	\$14.42	\$11.54	\$1.33
	Employee + Child(ren)	\$176.76	\$14.73	\$11.78	\$1.36
	Employee + Family	\$285.00	\$23.75	\$19.00	\$2.19

Please be advised that YBR will show rates as an annual amount when you enroll.

Life, AD&D and LTD Plans

Benefit Plan	Monthly Rate
Basic Life Insurance	Company Paid
Optional Life Insurance (Employee)	Rate per \$1,000 based on age
Age 0-24	\$0.050
Age 25-29	\$0.060
Age 30-34	\$0.080
Age 35-39	\$0.090
Age 40-44	\$0.152
Age 45-49	\$0.227
Age 50-54	\$0.353
Age 55-59	\$0.526
Age 60-64	\$0.714
Age 65-69	\$1.280
Age 70-99	\$2.300
Optional Life Insurance (Spouse)	Rate per \$1,000 based on age
Age 0-24	\$0.050
Age 25-29	\$0.060
Age 30-34	\$0.080
Age 35-39	\$0.090
Age 40-44	\$0.152
Age 45-49	\$0.227
Age 50-54	\$0.353
Age 55-59	\$0.526
Age 60-64	\$0.714
Age 65-69	\$1.280
Age 70-99	\$2.300
Basic Accidental Death & Dismemberment (AD&D)	Company Paid
Optional Accidental Death & Dismemberment (Employee)	\$0.020 per \$1,000
Optional Accidental Death & Dismemberment (Family)	\$0.032 per \$1,000
Basic Long-Term Disability (LTD) Pays up to 60% up to max of \$7,500/month	Company Paid
Optional LTD (Employee) Rate per \$100 of covered monthly salary Pays up to 66.66% up to max of \$20,000/month	\$0.15

**Metropolitan Life Insurance Co.
EXPLANATION OF BENEFITS
LONG TERM DISABILITY**

NAME OF EMPLOYEE: ██████████
DATE PROCESSED: 04/22/2013

REPORT/SUBCODE/SUBPOINT: 0096862 0001 0001
CLAIM NUMBER: 609707101450

Met DisAbility
*** SPECIAL HANDLING UNIT ***
P.O. Box 3017
Utica, NY 13504-3017
1-800-300-4296

THE INFORMATION ON THIS FORM PRESENTS AN EXPLANATION OF A CLAIM PROCESSED UNDER THE ABOVE PLAN. THIS FORM SHOULD BE SAVED FOR YOUR RECORDS. IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM OR HAVE RETURNED TO WORK, CONTACT METLIFE AT THE ABOVE ADDRESS. WHEN MAKING INQUIRIES PLEASE INCLUDE THE EMPLOYEE NAME, SOCIAL SECURITY NUMBER, CLAIM NUMBER AND REPORT/SUBCODE/SUBPOINT SHOWN AT THE TOP OF THE FORM.

IF THIS BENEFIT REPRESENTS PAYMENT BEYOND YOUR RETURN-TO-WORK DATE - DO NOT CASH. RETURN TO THE ABOVE ADDRESS. ANY ADJUSTMENT BENEFIT DUE WILL BE PROMPTLY ISSUED.

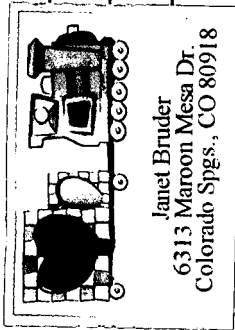
SUMMARY OF BENEFITS

BENEFIT START DATE: 06/12/1997 WAITING PERIOD: 6 MONTHS FIRST DATE OF DISABILITY: 12/12/1996
DAYS WORKED DURING DISABILITY: 0

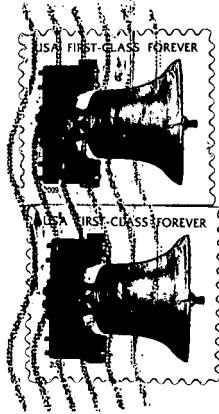
PAYMENTS:	BENEFITS PAID FROM	BENEFITS PAID THROUGH	MONTHS PAID	DAYS PAID	MONTHLY BENEFIT		NET PAYMENT
					AMOUNT	PAYMENT	
BENEFIT RATE	04/01/2013	04/30/2013	1		1,680.00	1,680.00	670.00

TAXES AND ADJUSTMENTS

TAXES:	MRTL STAT	EXPTS	AMOUNT	YTD TOTAL	ADJUSTMENTS:	AMOUNT
FEDERAL						
STATE						
FICA - OLD AGE						
FICA - MEDICARE						
LOCAL						
					PRIMARY SS DISABILITY BENEFITS	1,010.00



COLORADO SPRINGS
CO 809 1 T
07 MAY 2013 PM



BMC Group, Inc.
Attn: Conexant Systems, Inc. Claims Processing
PO Box 3020
Chanhassen, MN 55317-3020

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