[Your Organization's Logo]
[Your Organization's Name]
[Your Organization's Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]
Dear [Recipient's Name],
Subject: HFSA Eligibility Determination
We are pleased to inform you that your application for High Deductible Family Health Savings Account (HFSA) eligibility has been reviewed. After careful consideration, we have determined that you meet the necessary criteria.
Eligibility Details:
- **Name:** [Recipient's Name]
- **Member ID:** [Member ID]
- **Effective Date of Eligibility:** [Start Date]
Please review the following details regarding your HFSA eligibility:
1. **Contribution Limits:** You may contribute up to [Annual Contribution Limit] to your HFSA for the calendar year [Year].
2. **Qualified Expenses:** Eligible medical expenses include [list of qualified expenses].
3. **Account Management:** To manage your account and view transactions, please visit [website link].
If you have any questions or require further assistance, do not hesitate to contact our customer service team at [Customer Service Phone Number] or [Customer Service Email].
Thank you for choosing [Your Organization's Name] for your health savings needs.
Sincerely,
[Your Name]
[Your Title]
[Your Organization's Name]